

PROVIDER NO. 14-1318 OSF HOLY FAMILY MEDICAL CENTER
PERIOD FROM 10/01/2008 TO 09/30/2009

KPMG LLP COMPU-MAX MICRO SYSTEM
IN LIEU OF FORM CMS-2552-96 (05/2007)

VERSION: 2010.02
03/12/2010 16:14

HOSPITAL AND HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX ADDRESS:

1 STREET: 1000 WEST HARLEM AVENUE
1.01 CITY: MONMOUTH

STATE: IL

P.O.BOX:
ZIP CODE: 61462

COUNTY: WARREN

1
1.01

HOSPITAL AND HOSPITAL-BASED COMPONENT IDENTIFICATION:

COMPONENT 0	COMPONENT NAME 1	PROVIDER NUMBER 2	DATE CERTIFIED 3	PAYMENT SYSTEM (P,T,O OR N) V XVIII XIX 4 5 6	
2 HOSPITAL	OSF HOLY FAMILY MEDICAL CENTER	14-1318	05/01/2002	N O P	2
3 SUBPROVIDER I					3
4 SWING BEDS - SNF	OSF HOLY FAMILY SWING BEDS	14-2318	05/01/2002	N O N	4
5 SWING BEDS - NF					5
6 HOSPITAL-BASED SNF	OSF HOLY FAMILY LONG TERM CARE	14-5528	08/14/1985	N P N	6
7 HOSPITAL-BASED NF					7
8 HOSPITAL-BASED OLTC					8
9 HOSPITAL-BASED HHA					9
11 SEPARATELY CERTIFIED ASC					11
12 HOSPITAL-BASED HOSPICE					12
14 HOSP-BASED RHC	OSF HOLY FAMILY CLINICS	14-3461	02/05/2003	N O N	14
15 OUTPATIENT REHABILITATION PROVID					15
16 RENAL DIALYSIS					16
17 COST REPORTING PERIOD (MM/DD/YYYY)		FROM: 10/01/2008	TO: 09/30/2009		17
18 TYPE OF CONTROL					18
TYPE OF HOSPITAL/SUBPROVIDER					
19 HOSPITAL			1		19
20 SUBPROVIDER I					20

OTHER INFORMATION

21	INDICATE IF YOUR HOSPITAL IS EITHER (1) URBAN OR (2) RURAL AT THE END OF THE COST REPORTING PERIOD IN COLUMN 1. IF YOUR HOSPITAL IS GEOGRAPHICALLY CLASSIFIED OR LOCATED IN A RURAL AREA, IS YOUR BED SIZE IN ACCORDANCE WITH CFR 42 412.105 LESS THAN OR EQUAL TO 100 BEDS, ENTER IN COLUMN 2 'Y' FOR YES OR 'N' FOR NO.				21
21.01	DOES YOUR FACILITY QUALIFY AND IS CURRENTLY RECEIVING PAYMENT FOR DISPROPORTIONATE SHARE IN ACCORDANCE WITH 42 CFR 412.106? ENTER IN COLUMN 1 'Y' FOR YES OR 'N' FOR NO. IS THIS FACILITY SUBJECT TO THE PROVISIONS OF 42 CFR 412.106(c)(2) (PICKLE AMENDMENT HOSPITALS)? ENTER IN COLUMN 2 'Y' OR 'N' FOR NO.				21.01
21.02	HAS YOUR FACILITY RECEIVED GEOGRAPHIC RECLASSIFICATION? ENTER 'Y' FOR YES AND 'N' FOR NO. IF YES, REPORT IN COLUMN 2 THE EFFECTIVE DATE.				21.02
21.03	ENTER IN COLUMN 1 YOUR GEOGRAPHIC LOCATION EITHER (1) URBAN (2) RURAL. IF YOU ANSWERED URBAN IN COLUMN 1 INDICATE IF YOU RECEIVED EITHER A WAGE OR STANDARD GEOGRAPHIC RECLASSIFICATION TO A RURAL LOCATION, ENTER IN COLUMN 2 'Y' AND 'N' FOR NO. IF COLUMN 2 IS YES, ENTER IN COLUMN 3 THE EFFECTIVE DATE (mm/dd/yyyy) (SEE INSTRUCTION). DOES YOUR FACILITY CONTAIN 100 OR FEWER BEDS IN ACCORDANCE WITH 42 CFR 412.105? ENTER IN COLUMN 4 'Y' FOR YES AND 'N' FOR NO. ENTER IN COLUMN 5 THE PROVIDERS ACTUAL MSA OR CBSA.	2			21.03
21.04	FOR STANDARD GEOGRAPHIC RECLASSIFICATION (NOT WAGE), WHAT IS YOUR STATUS AT THE BEGINNING OF THE COST REPORTING PERIOD. ENTER (1) URBAN AND (2) RURAL.	2			21.04
21.05	FOR STANDARD GEOGRAPHIC RECLASSIFICATION (NOT WAGE), WHAT IS YOUR STATUS AT THE END OF THE COST REPORTING PERIOD. ENTER (1) URBAN AND (2) RURAL.	2			21.05
21.06	DOES THIS HOSPITAL QUALIFY FOR THE THREE-YEAR TRANSITION OF HOLD HARMLESS PAYMENTS FOR A SMALL RURAL HOSPITAL UNDER THE PROSPECTIVE PAYMENT SYSTEM FOR HOSPITAL OUTPATIENT SERVICES UNDER DRA SECTION 5105 OR MIPPA 147? (SEE INSTRUCTIONS). ENTER 'Y' FOR YES AND 'N' FOR NO.	NO			21.06
21.07	DOES THIS HOSPITAL QUALIFY AS AN SCH WITH UNDER 100 BEDS OR FEWER BEDS UNDER MIPPA 147? ENTER 'Y' FOR YES AND 'N' FOR NO (SEE INSTRUCTIONS).	NO			21.07
21.08	WHICH METHOD IS USED TO DETERMINE MEDICAID DAYS? ENTER IN COLUMN 1, 1 IF IT IS BASED ON DATE OF ADMISSION, 2 IF IT IS BASED ON CENSUS DAYS, OR 3 IF IT IS BASED ON DATE OF DISCHARGE. IS THIS METHOD DIFFERENT THAN THE METHOD USED IN THE LAST COST REPORTING PERIOD? ENTER IN COLUMN 2, 'Y' FOR YES AND 'N' FOR NO.				21.08
22	ARE YOU CLASSIFIED AS A REFERRAL CENTER?	NO			22
23	DOES THIS FACILITY OPERATE A TRANSPLANT CENTER? IF YES, ENTER CERTIFICATION DATE(S) BELOW	NO			23
23.01	IF THIS IS A MEDICARE CERTIFIED KIDNEY TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE IN COL. 2 AND TERMINATION IN COL. 3.				23.01
23.02	IF THIS IS A MEDICARE CERTIFIED HEART TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE IN COL. 2 AND TERMINATION IN COL. 3.				23.02
23.03	IF THIS IS A MEDICARE CERTIFIED LIVER TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE IN COL. 2 AND TERMINATION IN COL. 3.				23.03
23.04	IF THIS IS A MEDICARE CERTIFIED LUNG TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE IN COL. 2 AND TERMINATION IN COL. 3.				23.04
23.05	IF MEDICARE PANCREAS TRANSPLANTS ARE PERFORMED SEE INSTRUCTIONS FOR ENTERING CERTIFICATION AND TERMINATION DATE.				23.05
23.06	IF THIS IS A MEDICARE CERTIFIED INTESTINAL TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE IN COL. 2 AND TERMINATION IN COL. 3.				23.06
23.07	IF THIS IS A MEDICARE CERTIFIED ISLET TRANSPLANT CENTER ENTER THE CERTIFICATION DATE IN COL. 2 AND TERMINATION IN COL. 3.				23.07
24	IF THIS AN ORGAN PROCUREMENT ORGANIZATION (OPO), ENTER THE OPO NUMBER IN COL 2. AND TERMINATION IN COL. 3.				24
24.01	IF THIS A MEDICARE TRANSPLANT CENTER; ENTER THE CCN (PROVIDER NUMBER) IN COL 2, THE CERTIFICATION DATE OR RECERTIFICATION DATE (AFTER DECEMBER 26, 2007) IN COL 3.				24.01

HOSPITAL AND HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2
 (CONTINUED)

OTHER INFORMATION

25	IS THIS A TEACHING HOSPITAL OR AFFILIATED WITH A TEACHING HOSPITAL AND YOU ARE MAKING PAYMENTS FOR I & R?	NO							25
25.01	IS THIS TEACHING PROGRAM APPROVED IN ACCORDANCE WITH CMS PUB. 15-I, CHAPTER 4?	NO							25.01
25.02	IF LINE 25.01 IS YES, WAS MEDICARE PARTICIPATION AND APPROVED TEACHING PROGRAM STATUS IN EFFECT DURING THE FIRST MONTH OF THE COST REPORTING PERIOD? IF YES, COMPLETE WORKSHEET E-3, PART IV. IF NO, COMPLETE WORKSHEET D-2, PART II.	NO							25.02
25.03	AS A TEACHING HOSPITAL, DID YOU ELECT COST REIMBURSEMENT FOR PHYSICIANS' SERVICES AS DEFINED IN CMS PUB. 15-I, SECTION 2148? IF YES, COMPLETE WORKSHEET D-9.	NO							25.03
25.04	ARE YOU CLAIMING COSTS ON LINE 70 OF WORKSHEET A? IF YES, COMPLETE WORKSHEET D-2	NO							25.04
25.05	HAS YOUR FACILITY DIRECT GME FTE CAP (COLUMN 1) OR IME CAP (COLUMN 2) BEEN REDUCED UNDER 42 CFR 413.79(c)(3) OR 42 CFR 412.105(f)(1)(iv)(B)? ENTER 'Y' FOR YES AND 'N' FOR NO IN THE APPLICABLE COLUMNS. (SEE INSTRUCTIONS)								25.05
25.06	HAS YOUR FACILITY RECEIVED ADDITIONAL DIRECT GME FTE RESIDENT CAP SLOTS OR IME FTE RESIDENT CAP SLOTS UNDER 42 CFR 413.79(c)(4) OR 42 CFR 412.105(f)(1)(iv)(C)? ENTER 'Y' FOR YES AND 'N' FOR NO IN THE APPLICABLE COLUMNS. (SEE INSTRUCTIONS)								25.06
26	IF THIS A SOLE COMMUNITY HOSPITAL (SCH), ENTER THE NUMBER OF PERIODS SCH STATUS IN EFFECT. ENTER BEGINNING AND ENDING DATES OF SCH STATUS ON LINE 26.01. SUBSCRIPT LINE 26.01 FOR NUMBER OF PERIODS IN EXCESS OF ONE AND ENTER SUBSEQUENT DATES.								26
26.01	ENTER THE APPLICABLE SCH DATES: BEGINNING: ENDING:								26.01
26.03	IF THIS A SOLE COMMUNITY HOSPITAL (SCH) FOR ANY PART OF THE COST REPORTING PERIOD, ENTER THE NUMBER OF PERIODS WITHIN THIS COST REPORTING PERIOD THAT SCH STATUS WAS IN EFFECT AND THE SCH WAS EITHER PHYSICALLY LOCATED OR CLASSIFIED IN A RURAL AREA.								26.03
26.04	IF LINE 26.03 COLUMN 1 IS GREATER THAN ONE ENTER THE EFFECTIVE DATES (SEE INSTRUCTIONS): BEGINNING: ENDING: BEGINNING: ENDING:								26.04
27	DOES THIS HOSPITAL HAVE AN AGREEMENT UNDER EITHER SECTION 1883 OR SECTION 1913 FOR SWING BEDS? IF YES, ENTER THE AGREEMENT DATE (mm/dd/yyyy) IN COLUMN 2.	YES	05/01/2002						27
28	IF THIS FACILITY CONTAINS A HOSPITAL-BASED SNF, ARE ALL PATIENTS UNDER MANAGED CARE OR THERE WAS NO MEDICARE UTILIZATION ENTER 'Y', IF 'N' COMPLETE LINES 28.01 AND 28.02.	NO							28
28.01	IF HOSPITAL BASED SNF ENTER APPROPRIATE TRANSITION PERIOD 1, 2, 3, OR 100 IN COL 1, ENTER IN COLS 2 AND 3 THE WAGE INDEX ADJUSTMENT FACTOR BEFORE AND ON OR AFTER OCTOBER 1st	100	0.8386	0.8398					28.01
28.02	ENTER IN COL 1 THE HOSPITAL BASED SNF FACILITY SPECIFIC RATE (FROM YOUR F.I.) IF YOU HAVE NOT TRANSITIONED TO 100% PPS SNF PAYMENT. IN COL 2 ENTER THE FACILITY CLASSIFICATION URBAN(1) OR RURAL(2). IN COL 3, ENTER THE SNF MSA CODE OR TWO CHARACTER CODE IF A RURAL BASED FACILITY. IN COL 4, ENTER THE SNF CBSA CODE OR TWO CHARACTER CODE IF RURAL BASED FACILITY.	180.51	2	14	99914				28.02
A NOTICE PUBLISHED IN THE 'FEDERAL REGISTER' VOL. 68, NO. 149 AUGUST 4, 2003 PROVIDED FOR AN INCREASE IN THE RUG PAYMENTS BEGINNING 10/01/2003. CONGRESS EXPECTED THIS INCREASE TO BE USED FOR DIRECT PATIENT CARE AND RELATED EXPENSES. ENTER IN COLUMN 1 THE PERCENTAGE OF TOTAL EXPENSES FOR EACH CATEGORY TO TOTAL SNF REVENUE FROM WORKSHEET G-2, PART I, LINE 6, COLUMN 3. INDICATE IN COLUMN 2 'Y' FOR YES OR 'N' FOR NO IF THE SPENDING REFLECTS INCREASES ASSOCIATED WITH DIRECT PATIENT CARE AND RELATED EXPENSES FOR EACH CATEGORY. (SEE INSTRUCTIONS)									
28.03	STAFFING	100.00	YES						28.03
28.04	RECRUITMENT	0.00	NO						28.04
28.05	RETENTION OF EMPLOYEES	0.00	NO						28.05
28.06	TRAINING	0.00	NO						28.06
28.07	OTHER (SPECIFY)		NO						28.07
29	IS THIS A RURAL HOSPITAL WITH A CERTIFIED SNF WHICH HAS FEWER THAN 50 BEDS IN THE AGGREGATE FOR BOTH COMPONENTS, USING THE SWING BED OPTIONAL METHOD OF REIMBURSEMENT?	NO							29
30	DOES THIS HOSPITAL QUALIFY AS A RURAL PRIMARY CARE HOSPITAL (RPCH)/CRITICAL ACCESS HOSPITAL (CAH)? SEE 42 CFR 485.606ff.	YES							30
30.01	IF SO, IS THIS THE INITIAL 12 MONTH PERIOD FOR THE FACILITY OPERATED AS A RPCH/CAH? SEE 42 CFR 413.70.	NO							30.01
30.02	IF THIS FACILITY QUALIFIES AS AN RPCH/CAH, HAS IT ELECTED THE ALL-INCLUSIVE METHOD OF PAYMENT FOR OUTPATIENT SERVICES?	NO							30.02
30.03	IF THIS FACILITY QUALIFIES AS A CAH, IS IT ELIGIBLE FOR COST REIMBURSEMENT FOR AMBULANCE SERVICES? IF YES, ENTER IN COLUMN 2 THE DATE OF ELIGIBILITY DETERMINATION (DATE MUST BE ON OR AFTER 12/21/2000)	NO							30.03
30.04	IF THIS FACILITY QUALIFIES AS A CAH, IS IT ELIGIBLE FOR COST REIMBURSEMENT FOR I&R TRAINING PROGRAMS? ENTER 'Y' FOR YES AND 'N' FOR NO. IF YES, THE GME ELIMINATION WOULD NOT BE ON WORKSHEET B, PART I, COLUMN 26 AND THE PROGRAM WOULD BE COST REIMBURSED. IF YES COMPLETE WORKSHEET D-2, PART II.	NO							30.04
31	IS THIS A RURAL HOSPITAL QUALIFYING FOR AN EXCEPTION TO THE CRNA FEE SCHEDULE? SEE 42 CFR 412.113(c).	NO							31

HOSPITAL AND HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2
(CONTINUED)

MISCELLANEOUS COST REPORTING INFORMATION

32	IS THIS AN ALL-INCLUSIVE RATE PROVIDER? IF YES, ENTER THE METHOD USED (A, B, OR E ONLY) IN COLUMN 2.	NO		32
33	IS THIS A NEW HOSPITAL UNDER 42 CFR 412.300 PPS CAPITAL? ENTER 'Y' FOR YES AND 'N' FOR NO IN COLUMN 1. IF YES, FOR COST REPORTING PERIODS BEGINNING ON OR AFTER OCTOBER 1, 2002, DO YOU ELECT TO BE REIMBURSED AT 100% FEDERAL CAPITAL PAYMENT. ENTER 'Y' FOR YES AND 'N' FOR NO IN COLUMN 2.	NO		33
34	IS THIS A NEW HOSPITAL UNDER 42 CFR 413.40(f)(1)(i) TEFRA?	NO		34
35	HAVE YOU ESTABLISHED A NEW SUBPROVIDER I (EXCLUDED UNIT) UNDER 42 CFR 413.40(f)(1)(i)?	NO		35

PROSPECTIVE PAYMENT SYSTEM (PPS) - CAPITAL

36	DO YOU ELECT FULLY PROSPECTIVE PAYMENT METHODOLOGY FOR CAPITAL COSTS?	NO	1	XVIII	XIX	
36.01	DOES YOUR FACILITY QUALIFY AND RECEIVE PAYMENT FOR DISPROPORTIONATE SHARE IN ACCORDANCE WITH 42CFR412.320?	NO	NO	NO	NO	36
37	DO YOU ELECT HOLD HARMLESS PAYMENT METHODOLOGY FOR CAPITAL COSTS?	NO	NO	NO	NO	37
37.01	IF YOU ARE A HOLD HARMLESS PROVIDER, ARE YOU FILING ON THE BASIS OF 100% OF FEDERAL RATE?					37.01

TITLE XIX INPATIENT HOSPITAL SERVICES

38	DO YOU HAVE TITLE XIX INPATIENT HOSPITAL SERVICES?	YES		38
38.01	IS THIS HOSPITAL REIMBURSED FOR TITLE XIX THROUGH THE COST REPORT EITHER IN FULL OR IN PART?	NO		38.01
38.02	DOES THE TITLE XIX PROGRAM REDUCE CAPITAL FOLLOWING THE MEDICARE METHODOLOGY?	YES		38.02
38.03	ARE TITLE XIX NF PATIENTS OCCUPYING TITLE XVIII SNF BEDS (DUAL CERTIFICATION)?	NO		38.03
38.04	DO YOU OPERATE AN ICF/MR FACILITY FOR PURPOSES OF TITLE XIX?	NO		38.04
40	ARE THERE ANY RELATED ORGANIZATION OR HOME OFFICE COSTS AS DEFINED IN CMS PUB. 15-I, CHAPTER 10? IF YES, AND THIS FACILITY IS PART OF A CHAIN ORGANIZATION, ENTER IN COL. 2 THE HOME OFFICE CHAIN NUMBER. (SEE INST.) IF THIS FACILITY IS PART OF A CHAIN ORGANIZATION, ENTER THE NAME AND ADDRESS OF THE HOME OFFICE ON LINES 40.01-40.03.	YES	149006	40
40.01	NAME: OSF HEALTHCARE SYSTEM		FI/CONTRACTOR'S NAME: 14-9006	40.01
40.02	STREET: 800 N.E. GLEN OAK AVENUE		FI/CONTRACTOR'S NUMBER: 52280	40.02
40.03	CITY: PEORIA, IL 61603		P.O.BOX:	40.03
41	ARE PROVIDER BASED PHYSICIANS' COSTS INCLUDED IN WORKSHEET A?	YES	STATE:	41
42	ARE PHYSICAL THERAPY SERVICES PROVIDED BY OUTSIDE SUPPLIERS?	YES	ZIP CODE:	42
42.01	ARE OCCUPATIONAL THERAPY SERVICES PROVIDED BY OUTSIDE SUPPLIERS?	NO		42.01
42.02	ARE SPEECH PATHOLOGY SERVICES PROVIDED BY OUTSIDE SUPPLIERS?	YES		42.02
43	ARE RESPIRATORY THERAPY SERVICES PROVIDED BY OUTSIDE PROVIDERS?	NO		43
44	IF YOU ARE CLAIMING COST FOR RENAL SERVICES ON WORKSHEET A, ARE THEY INPAT SERVICES ONLY?	NO		44
45	HAVE YOU CHANGED YOUR COST ALLOCATION METHODOLOGY FROM THE PREVIOUSLY FILE COST REPORT? SEE CMS PUB. 15-II, SECTION 3617. IF YES, ENTER THE APPROVAL DATE (mm/dd/yyyy) IN COLUMN 2.	NO		45
45.01	WAS THERE A CHANGE IN THE STATISTICAL BASIS?			45.01
45.02	WAS THERE A CHANGE IN THE ORDER OF ALLOCATION?			45.02
45.03	WAS THERE A CHANGE TO THE SIMPLIFIED COST FINDING METHOD?			45.03
46	IF YOU ARE PARTICIPATING IN THE NHCMQ DEMONSTRATION PROJECT (MUST HAVE A HOSPITAL-BASED SNF) DURING THIS COST REPORTING PERIOD, ENTER THE PHASE.			46

IF THIS FACILITY CONTAINS A PROVIDER THAT QUALIFIES FOR AN EXEMPTION FROM THE APPLICATION OF THE LOWER OF COST OR CHARGES, ENTER A 'Y' FOR EACH COMPONENT AND TYPE OF SERVICE THAT QUALIFIES FOR THE EXEMPTION; ENTER 'N' IF NOT EXEMPT (SEE 42 CFR 413.13).

	PART A	PART B	OUTPATIENT ASC	OUTPATIENT RADIOLOGY	OUTPATIENT DIAGNOSTIC	
	1	2	3	4	5	
47	HOSPITAL	N	N	N	N	47
48	SUBPROVIDER I	N	N	N	N	48
49	SKILLED NURSING FACILITY	N	N			49
50	HOME HEALTH AGENCY	N	N			50
52	DOES THIS HOSPITAL CLAIM EXPENDITURES FOR EXTRAORDINARY CIRCUMSTANCES IN ACCORDANCE WITH 42 CFR 412.348(e)?			NO		52
52.01	IF YOU ARE A FULLY PROSPECTIVE OR HOLD HARMLESS PROVIDER ARE YOU ELIGIBLE FOR THE SPECIAL EXCEPTION PAYMENT PURSUANT TO 42 CFR 412.348(g)? IF YES, COMPLETE L, PART IV.			NO		52.01
53	IF THIS IS A MEDICARE DEPENDENT HOSPITAL (MDH), ENTER THE NUMBER OF PERIODS MDH STATUS IN EFFECT. ENTER BEGINNING AND ENDING DATES OF MDH STATUS ON LINE 53.01. SUBSCRIPT LINE 53.01 FOR NUMBER OF PERIODS IN EXCESS OF ONE AND ENTER SUBSEQUENT DATES.					53
53.01	MDH PERIOD:	BEGINNING:		ENDING:		53.01
54	LIST AMOUNTS OF MALPRACTICE PREMIUMS AND PAID LOSSES:					54
	PREMIUMS: 222848	PAID LOSSES:		AND/OR SELF INSURANCE:		
54.01	ARE MALPRACTICE PREMIUMS AND PAID LOSSES REPORTED IN OTHER THAN THE ADMINISTRATIVE AND GENERAL COST CENTER? IF YES, SUBMIT SUPPORTING SCHEDULE LISTING COST CENTERS AND AMOUNTS CONTAINED THEREIN.			NO		54.01
55	DOES YOUR FACILITY QUALIFY FOR ADDITIONAL PROSPECTIVE PAYMENT IN ACCORDANCE WITH 42 CFR 412.107. ENTER 'Y' FOR YES AND 'N' FOR NO.			NO		55

HOSPITAL AND HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2
 (CONTINUED)

	DATE 0 / /	Y/N 1 NO	LIMIT 2 0.00	Y/N 3 NO	FEE\$ 4	
56	ARE YOU CLAIMING AMBULANCE COSTS? IF YES, ENTER IN COL 2 THE PAYMENT LIMIT PROVIDED FROM YOUR FISCAL INTERMEDIARY. IF THIS IS FIRST YEAR OF OPERATIONS, NO ENTRY IS REQUIRED IN COL 2. IF COL 1 IS 'Y', ENTER 'Y' OR 'N' IN COL 3 WHETHER THIS IS YOUR FIRST YEAR OF OPERATIONS FOR RENDERING AMBULANCE SERVICES. ENTER IN COL 4, IF APPLICABLE, THE FEE SCHEDULES AMOUNTS FOR THE PERIOD BEGINNING ON OR AFTER 4/1/2002.					56
57	ARE YOU CLAIMING NURSING AND ALLIED HEALTH COSTS?					57
58	ARE YOU AN INPATIENT REHABILITATION FACILITY (IRF), OR DO YOU CONTAIN AN IRF SUBPROVIDER? ENTER IN COLUMN 1 'Y' FOR YES AND 'N' FOR NO. IF YES HAVE YOU MADE THE ELECTION FOR 100% PPS REIMBURSEMENT? ENTER IN COLUMN 2 'Y' FOR YES AND 'N' FOR NO. THIS OPTION IS ONLY AVAILABLE FOR COST REPORTING PERIODS BEGINNING ON OR AFTER 1/1/2002 AND BEFORE 10/1/2002.					58
58.01	IF LINE 58 COLUMN 1 IS Y, DOES THE FACILITY HAVE A TEACHING PROGRAM IN THE MOST RECENT COST REPORTING PERIOD ENDING ON OR BEFORE NOVEMBER 15, 2004? ENTER IN COLUMN 1 'Y' FOR YES OR 'N' FOR NO. IS THE FACILITY TRAINING RESIDENTS IN A NEW TEACHING PROGRAM IN ACCORDANCE WITH FR VOL 70, NO 156 DATED AUGUST 15, 2005 PAGE 47929? ENTER IN COLUMN 2 'Y' FOR YES OR 'N' FOR NO. IF COLUMN 2 IS Y, ENTER 1, 2, OR 3 RESPECTIVELY IN COLUMN 3 (SEE INSTRUCTIONS) IF THE CURRENT COST REPORTING PERIOD COVERS THE BEGINNING OF THE FOURTH ENTER 4 IN COLUMN 3, OR IF THE SUBSEQUENT ACADEMIC YEARS OF THE NEW TEACHING PROGRAM IN EXISTENCE, ENTER 5. (SEE INSTRUCTIONS)					58.01
59	ARE YOU A LONG TERM CARE HOSPITAL (LTCH), OR DO YOU CONTAIN A LTCH SUBPROVIDER? ENTER IN COLUMN 1 'Y' FOR YES AND 'N' FOR NO. IF YES HAVE YOU MADE THE ELECTION FOR 100% PPS REIMBURSEMENT? ENTER IN COLUMN 2 'Y' FOR YES AND 'N' FOR NO. (SEE INSTRUCTIONS)					59
60	ARE YOU AN INPATIENT PSYCHIATRIC FACILITY (IPF), OR DO YOU CONTAIN AN IPF SUBPROVIDER? ENTER IN COLUMN 1 'Y' FOR YES AND 'N' FOR NO. IF YES, IS THE IPF OR IPF SUBPROVIDER A NEW FACILITY? ENTER IN COLUMN 2 'Y' FOR YES AND 'N' FOR NO. (SEE INSTRUCTIONS)					60
60.01	IF LINE 60 COLUMN 1 IS Y, DOES THE FACILITY HAVE A TEACHING PROGRAM IN THE MOST RECENT COST REPORTING PERIOD ENDING ON OR BEFORE NOVEMBER 15, 2004? ENTER 'Y' FOR YES OR 'N' FOR NO. IS THE FACILITY TRAINING RESIDENTS IN A NEW TEACHING PROGRAM IN ACCORDANCE WITH 42 CFR SEC. 412.424(d)(1)(iii)(2)? ENTER IN COLUMN 2 'Y' FOR YES OR 'N' FOR NO. IF COLUMN 2 IS Y, ENTER 1, 2, OR 3 RESPECTIVELY IN COLUMN 3 (SEE INSTRUCTIONS). IF THE CURRENT COST REPORTING PERIOD COVERS THE BEGINNING OF THE FOURTH ENTER 4 IN COLUMN 3, OR IF THE SUBSEQUENT ACADEMIC YEARS OF THE NEW TEACHING PROGRAM IN EXISTENCE, ENTER 5 (SEE INSTR.)					60.01
MULTICAMPUS						
61	DOES THE HOSPITAL HAVE A MULTICAMPUS? ENTER 'Y' FOR YES AND 'N' FOR NO. IF LINE 61 IS YES, ENTER THE NAME IN COL. 0, COUNTY IN COL. 1, STATE IN COL. 2, ZIP IN COL. 3, CBSA IN COL. 4 AND FTE/CAMPUS IN COL. 5.					61
	COUNTY: 1	STATE: 2	ZIP CODE 3	CBSA 4	FTE/ CAMPUS 5	
SETTLEMENT DATA						
63	WAS THE COST REPORT FILED USING THE PS&R (EITHER IN ITS ENTIRETY OR FOR TOTAL CHARGES AND DAYS ONLY)? ENTER 'Y' FOR YES AND 'N' FOR NO IN COLUMN 1. IF COLUMN 1 IS 'Y', ENTER THE 'PAID THROUGH' DATE OF THE PS&R IN COLUMN 2 (mm/dd/yyyy)					63

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WORKSHEET S-3

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PROVIDER NO. 14-1318 OSF HOLY FAMILY MEDICAL CENTER
 PERIOD FROM 10/01/2008 TO 09/30/2009

KPMG LLP COMPU-MAX MICRO SYSTEM
 IN LIEU OF FORM CMS-2552-96 (9/2000)

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HOSPITAL AND HEALTH CARE COMPLEX STATISTICAL DATA

WORKSHEET S-3
 PART I
 (CONTINUED)

		-----DISCHARGES-----				
COMPONENT		TITLE V 12	TITLE XVIII 13	TITLE XIX 14	TOTAL ALL PATIENTS 15	
1	HOSPITAL ADULTS & PEDS, EXCL. SWING BED, OBSERV & HOSPICE DAYS		364	38	538	1
2	HMO XIX					2
3	HOSPITAL ADULTS & PEDS - SWING BED SNF					3
4	HOSPITAL ADULTS & PEDS - SWING BED NF					4
5	TOTAL ADULTS & PEDS EXCL OBSERVATION BEDS					5
6	INTENSIVE CARE UNIT					6
7	CORONARY CARE UNIT					7
8	BURN INTENSIVE CARE UNIT					8
9	SURGICAL INTENSIVE CARE UNIT					9
10	OTHER SPECIAL CARE (SPECIFY)					10
11	NURSERY					11
12	TOTAL HOSPITAL		364	38	538	12
13	RPCH VISITS					13
14	SUBPROVIDER I					14
15	SKILLED NURSING FACILITY					15
16	NURSING FACILITY					16
17	OTHER LONG TERM CARE					17
18	HOME HEALTH AGENCY					18
20	ASC (DISTINCT PART)					20
21	HOSPICE (DISTINCT PART)					21
23	O/P REHAB PROVIDER					23
24	RHC I					24
25	TOTAL					25
26	OBSERVATION BED DAYS					26
27	AMBULANCE TRIPS					27
28	EMPLOYEE DISCOUNT DAYS					28

HOSPITAL WAGE INDEX INFORMATION

PART II - WAGE DATA		AMOUNT REPORTED	RECLASS. OF SALARIES FROM WKST. A-6	ADJUSTED SALARIES (COL.1 + COL.2)	PAID HOURS RELATED TO SALARY IN COL.3	AVERAGE HOURLY WAGE (COL.3 / COL.4)	DATA SOURCE	WORKSHEET S-3 PART II
		1	2	3	4	5	6	
1	SALARIES							1
2	TOTAL SALARIES	11470321	2857933					2
3	NON-PHYSICIAN ANESTHETIST PART A							3
4	NON-PHYSICIAN ANESTHETIST PART B							4
4.01	PHYSICIAN - PART A							4.01
5	TEACHING PHYSICIAN SALARIES							5
5.01	PHYSICIAN - PART B							5.01
6	NON-PHYSICIAN - PART B							6
6.01	INTERNS & RESIDENTS (IN APPR PGM)							6.01
7	CONTRACT SERVICES, I&R							7
8	HOME OFFICE PERSONNEL							8
8.01	SNF	873855						8.01
	EXCLUDED AREA SALARIES	893865	-56318					
	OTHER WAGES & RELATED COSTS							
9	CONTRACT LABOR							9
9.01	PHARMACY SERVICES UNDER CONTRACT							9.01
9.02	LABORATORY SERVICES UNDER CONTRACT							9.02
9.03	MANAGEMENT AND ADMINISTRATIVE SERVICES							9.03
10	CONTRACT LABOR: PHYSICIAN PART A							10
10.01	TEACHING PHYSICIAN UNDER CONTRACT							10.01
11	HOME OFFICE SALARIES & WAGE REL COSTS							11
12	HOME OFFICE: PHYSICIAN PART A							12
12.01	TEACHING PHYSICIAN SALARIES							12.01
	WAGE-RELATED COSTS							
13	WAGE RELATED COSTS (CORE)					CMS 339		13
14	WAGE RELATED COSTS (OTHER)					CMS 339		14
15	EXCLUDED AREAS					CMS 339		15
16	NON-PHYSICIAN ANESTHETIST PART A					CMS 339		16
17	NON-PHYSICIAN ANESTHETIST PART B					CMS 339		17
18	PHYSICIAN PART A					CMS 339		18
18.01	PART A TEACHING PHYSICIANS					CMS 339		18.01
19	PHYSICIAN PART B					CMS 339		19
19.01	WAGE RELATED COSTS (RHC/FQHC)					CMS 339		19.01
20	INTERNS & RESIDENTS (IN APPR PGM)					CMS 339		20
	OVERHEAD COSTS - DIRECT SALARIES							
21	EMPLOYEE BENEFITS	23441	2857933					21
22	ADMINISTRATIVE & GENERAL	1958970	56318					22
22.01	ADMINISTRATIVE & GENERAL UNDER CONTACT							22.01
23	MAINTENANCE & REPAIRS							23
24	OPERATION OF PLANT	499813						24
25	LAUNDRY & LINEN SERVICE							25
26	HOUSEKEEPING	335457						26
26.01	HOUSEKEEPING UNDER CONTRACT							26.01
27	DIETARY	334390						27
27.01	DIETARY UNDER CONTRACT							27.01
28	CAFETERIA							28
29	MAINTENANCE OF PERSONNEL							29
30	NURSING ADMINISTRATION							30
31	CENTRAL SERVICES AND SUPPLY							31
32	PHARMACY							32
33	MEDICAL RECORDS & MEDICAL RECORDS LIBR	181405						33
34	SOCIAL SERVICE							34
35	OTHER GENERAL SERVICE							35

HOSPITAL WAGE INDEX INFORMATION

WORKSHEET S-3
 PART III

PART III - HOSPITAL WAGE INDEX SUMMARY		AMOUNT REPORTED	RECLASS. OF SALARIES FROM WKST. A-6	ADJUSTED SALARIES (COL.1 + COL.2)	PAID HOURS RELATED TO SALARY IN COL.3	AVERAGE HOURLY WAGE (COL.3 / COL.4)	
		1	2	3	4	5	
1	NET SALARIES	11470321	2857933	14328254			1
2	EXCLUDED AREA SALARIES	1767720	-56318	1711402			2
3	SUBTOTAL SALARIES (LINE 1 MINUS LINE 2)	9702601	2914251	12616852			3
4	SUBTOTAL OTHER WAGES & REL COSTS						4
5	SUBTOTAL WAGE-RELATED COSTS						5
6	TOTAL (SUM OF LINES 3 THRU 5)	9702601	2914251	12616852			6
7	NET SALARIES						7
8	EXCLUDED AREA SALARIES						8
9	SUBTOTAL SALARIES (LINE 7 MINUS LINE 8)						9
10	SUBTOTAL OTHER WAGES & REL COSTS						10
11	SUBTOTAL WAGE-RELATED COSTS						11
12	TOTAL (SUM OF LINES 9 THRU 11)						12
13	TOTAL OVERHEAD COSTS	3333476	2914251	6247727			13

PROVIDER NO. 14-1318 OSF HOLY FAMILY MEDICAL CENTER
 PERIOD FROM 10/01/2008 TO 09/30/2009

KPMG LLP COMPU-MAX MICRO SYSTEM
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PROSPECTIVE PAYMENT FOR SNF
 STATISTICAL DATA

WORKSHEET S-7

GROUP (1)	M3PI REVENUE CODE	SERVICES PRIOR TO OCTOBER 1st		SERVICES ON OR AFTER OCTOBER 1st		SERVICES THROUGH 4/1/2001 - 9/30/2001		SWING BED SNF DAYS	TOTAL
		RATE	DAYS	RATE	DAYS	RATE	DAYS		
1	2	3	3.01	4	4.01	4.02	4.03	4.06	5
1	RUC								1
2	RUB								2
3	RUA								3
3.01	RUX								3.01
3.02	RUL								3.02
4	RVC								4
5	RVB								5
6	RVA								6
6.01	RVX								6.01
6.02	RVL								6.02
7	RHC		46						7
8	RHB		20						8
9	RHA								9
9.01	RHX								9.01
9.02	RHL								9.02
10	RMC		46						10
11	RMB		61						11
12	RMA								12
12.01	RMX								12.01
12.02	RML								12.02
13	RLB								13
14	RLA								14
14.01	RLX								14.01
15	SE3								15
16	SE2		13						16
17	SE1								17
18	SSC								18
19	SSB								19
20	SSA								20
21	CC2		26						21
22	CC1		3						22
23	CB2								23
24	CB1		39						24
25	CA2								25
26	CA1		17						26
27	IB2								27
28	IB1								28
29	IA2								29
30	IA1								30
31	BB2								31
32	BB1								32
33	BA2								33
34	BA1								34
35	PE2								35
36	PE1								36
37	PD2								37
38	PD1								38
39	PC2								39
40	PC1								40
41	PB2								41
42	PB1		9						42
43	PA2								43
44	PA1		3						44
45	DEFAULT RATE								45
46	TOTAL		283						46

PROVIDER NO. 14-1318 OSF HOLY FAMILY MEDICAL CENTER
PERIOD FROM 10/01/2008 TO 09/30/2009

KPMG LLP COMPU-MAX MICRO SYSTEM
IN LIEU OF FORM CMS-2552-96 (11/98)

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PROVIDER-BASED RURAL HEALTH CLINIC/
FEDERALLY QUALIFIED HEALTH CENTER
PROVIDER STATISTICAL DATA

RHC I
COMPONENT NO: 14-3461

WORKSHEET S-8

CHECK APPLICABLE BOX: [XX] RHC [] FQHC

CLINIC ADDRESS AND IDENTIFICATION:

1	STREET: 1000 WEST HARLEM AVENUE						1
1.01	CITY: MONMOUTH	STATE: IL	ZIP CODE: 61462	COUNTY: WARREN			1.01
2	DESIGNATION (FOR FQHCs ONLY) - ENTER 'R' FOR RURAL OR 'U' FOR URBAN						2

SOURCE OF FEDERAL FUNDS:

GRANT AWARD

DATE

		1	2	
3	COMMUNITY HEALTH CENTER (SECTION 330(d), PHS ACT)	/	/	3
4	MIGRANT HEALTH CENTER (SECTION 329(d), PHS ACT)	/	/	4
5	HEALTH SERVICES FOR HOMELESS (SECTION 340(d), PHS ACT)	/	/	5
6	APPALACHIAN REGIONAL COMMISSION	/	/	6
7	LOOK-ALIKES	/	/	7
8	OTHER	/	/	8

PHYSICIAN INFORMATION:

PHYSICIAN NAME

BILLING NO.

9	PHYSICIAN(S) FURNISHING SERVICES AT THE CLINIC OR UNDER AGREEMENT			9
---	--	--	--	---

PHYSICIAN NAME

HOURS

10	SUPERVISORY PHYSICIAN(S) AND HOURS OF SUPERVISION DURING PERIOD			10
----	--	--	--	----

11	DOES THIS FACILITY OPERATE AS OTHER THAN AN RHC OR FQHC? IF YES, INDICATE NUMBER OF OTHER OPERATIONS IN COLUMN 2 (ENTER IN SUBSCRIPTS OF LINE 12 THE TYPE OF OTHER OPERATION(S) AND THE OPERATING HOURS)	NO		11
----	--	----	--	----

FACILITY HOURS OF OPERATIONS (1)

TYPE OPERATION	SUNDAY		MONDAY		TUESDAY		WEDNESDAY		THURSDAY		FRIDAY		SATURDAY		
	FROM	TO	FROM	TO	FROM	TO	FROM	TO	FROM	TO	FROM	TO	FROM	TO	
0	1	2	3	4	5	6	7	8	9	10	11	12	13	14	
12 CLINIC	700	2200	700	2200	700	2200	700	2200	700	2200	700	2200	700	2200	12

(1) ENTER CLINIC HRS OF OPERATION ON LNE 12 & OTHER TYPE OPERATIONS ON SUBSCRIPTS OF LNE 12 (BOTH TYPE & HRS OF OPERATION)
LIST HOURS OF OPERATION BASED ON A 24 HOUR CLOCK. FOR EXAMPLE: 8:00AM IS 0800, 6:30PM IS 1830, AND MIDNIGHT IS 2400.

13	HAVE YOU RECEIVED AN APPROVAL FOR AN EXCEPTION TO THE PRODUCTIVITY STANDARD?	NO		13
14	IS THIS A CONSOLIDATED COST REPORT AS DEFINED IN CMS PUB 27, SECTION 508(D)?	NO		14
	IF YES, ENTER IN COLUMN 2 THE NUMBER OF PROVIDERS IN THIS COST REPORT.			
	LIST THE NAMES OF ALL PROVIDERS AND NUMBERS BELOW.			
15	PROVIDER NAME:	PROVIDER NUMBER:	-	15
		V	XVIII	XIX
16	HAVE YOU PROVIDED ALL OR SUBSTANTIALLY ALL GME COSTS? IF YES, ENTER IN COLUMNS 2, 3, AND 4 THE NUMBER OF MEDICARE VISITS PERFORMED BY INTERNS AND RESIDENTS.	NO		16
17	HAS THE HOSPITAL'S BED SIZE CHANGED TO LESS THAN 50 BEDS DURING THE YEAR FOR COST REPORTING PERIODS OVERLAPPING 7/1/2001? ENTER 'Y' FOR YES AND 'N' FOR NO. IF YES, SEE INSTRUCTIONS.	NO		17

RECLASSIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF EXPENSES

WORKSHEET A

	COST CENTER	SALARIES 1	OTHER 2	TOTAL 3	RECLASSI- FICATIONS 4	RECLASS. TRIAL BALANCE 5	ADJUST- MENTS 6	NET EXP FOR ALLOCATION 7	
	GENERAL SERVICE COST CENTERS								
1	0100 OLD CAP REL COSTS-BLDG & FIXT								1
2	0200 OLD CAP REL COSTS-MVBLE EQUIP								2
3	0300 NEW CAP REL COSTS-BLDG & FIXT		67492	67492	2147	69639		69639	3
4	0400 NEW CAP REL COSTS-MVBLE EQUIP		962374	962374	98116	1060490	-7784	1052706	4
4.01	0401 NEW CAP REL COSTS-MVBLE EQUIP N		42742	42742	1360	44102		44102	4.01
5	0500 EMPLOYEE BENEFITS	23441	47714	71155	2789374	2860529	-72015	2788514	5
6	0600 ADMINISTRATIVE & GENERAL	1658970	2772373	4731343	-558208	4173135	659503	4832638	6
7	0700 MAINTENANCE & REPAIRS								7
8	0800 OPERATION OF PLANT	499813	979010	1478823	-201715	1277108		1277108	8
9	0900 LAUNDRY & LINEN SERVICE		106424	106424		106424		106424	9
10	1000 HOUSEKEEPING	335457	197349	532806	-132152	400654		400654	10
11	1100 DIETARY	334390	446228	780618	-140505	640113	-43193	596920	11
12	1200 CAFETERIA								12
13	1300 MAINTENANCE OF PERSONNEL								13
14	1400 NURSING ADMINISTRATION								14
15	1500 CENTRAL SERVICES & SUPPLY								15
16	1600 PHARMACY								16
17	1700 MEDICAL RECORDS & LIBRARY	181405	75158	256563	-27490	229073	-6204	222869	17
18	1800 SOCIAL SERVICE								18
20	2000 NONPHYSICIAN ANESTHETISTS								20
21	2100 NURSING SCHOOL								21
22	2200 I&R SERVICES-SALARY & FRINGES A								22
23	2300 I&R SERVICES-OTHER PRGM COSTS A								23
24	2400 PARAMED ED PRGM-(SPECIFY)								24
	INPATIENT ROUTINE SERV COST CENTERS								
25	2500 ADULTS & PEDIATRICS	1017073	318443	1335516	-268212	1067304		1067304	25
34	3400 SKILLED NURSING FACILITY	873855	273238	1147093	-247377	899716		899716	34
	ANCILLARY SERVICE COST CENTERS								
37	3700 OPERATING ROOM	347699	495120	842819	-388580	454239		454239	37
38	3800 RECOVERY ROOM								38
40	4000 ANESTHESIOLOGY	291423	94655	386078	-79442	306636	-296327	10309	40
41	4100 RADIOLOGY-DIAGNOSTIC	408126	1057232	1465358	-255767	1209591		1209591	41
44	4400 LABORATORY	373272	779331	1152603	-99861	1052742	-16100	1036642	44
46.30	4650 BLOOD CLOTTING FACTORS ADMIN CO								46.30
49	4900 RESPIRATORY THERAPY	26055	36519	62574	-13308	49266		49266	49
50	5000 PHYSICAL THERAPY	267607	155811	423418	-75943	347475	-4061	343414	50
51	5100 OCCUPATIONAL THERAPY	74857	15509	90366	-15179	75187		75187	51
52	5200 SPEECH PATHOLOGY		6990	6990		6990		6990	52
53	5300 ELECTROCARDIOLOGY	145440	57125	202565	-44550	158015		158015	53
55	5500 MEDICAL SUPPLIES CHARGED TO PAT	18747	33728	52475	370856	423331		423331	55
56	5600 DRUGS CHARGED TO PATIENTS	256761	438738	695499	64039	759538		759538	56
59.97	3997 CARDIAC REHABILITATION								59.97
59.98	3998 HYPERBARIC OXYGEN THERAPY								59.98
59.99	3999 LITHOTRIPSY								59.99
	OUTPATIENT SERVICE COST CENTERS								
61	6100 EMERGENCY	790916	307783	1098699	-109233	989466	-274155	715311	61
62	6200 OBSERVATION BEDS (NON-DISTINCT								62
63.50	6310 RHC	2351149	944456	3295605	-414224	2881381	-20031	2861350	63.50
63.60	6320 FQHC								63.60
	OTHER REIMBURSABLE COST CENTERS								
69.10	6910 CMHC								69.10
69.20	6920 OUTPATIENT PHYSICAL THERAPY								69.20
69.30	6930 OUTPATIENT OCCUPATIONAL THERAPY								69.30
69.40	6940 OUTPATIENT SPEECH PATHOLOGY								69.40
71	7100 HOME HEALTH AGENCY								71
	SPECIAL PURPOSE COST CENTERS								
85.01	8510 PANCREAS ACQUISITION								85.01
85.02	8520 INTESTINAL ACQUISITION								85.02
85.03	8530 ISLET CELL ACQUISITION								85.03
88	8800 INTEREST EXPENSE		468667	468667	-67500	401167	-401167		88
95	SUBTOTALS	10576456	11180209	21756665	186646	21943311	-481534	21461777	95
	NONREIMBURSABLE COST CENTERS								
98	9800 PHYSICIANS' PRIVATE OFFICES	893865	221835	1115700	-186646	929054		929054	98
100	7950 CLINIC								100
100.01	7951 RENTAL SPACE								100.01
101	TOTAL	11470321	11402044	22872365		22872365	-481534	22390831	101

RECLASSIFICATIONS

WORKSHEET A-6
 PAGE 1

EXPLANATION OF RECLASSIFICATION ENTRY		CODE	----- INCREASE -----			
			COST CENTER	LINE #	SALARY	OTHER
		1	2	3	4	5
1	TO RECLASS INTEREST EXPENSE	A	NEW CAP REL COSTS-MVBLE EQUIP	4		67500
2	TO RECLASS MEDICAL SUPPLIES	C	MEDICAL SUPPLIES CHARGED TO P	55		370856
3		C	DRUGS CHARGED TO PATIENTS	56		115664
4		C				
5		C				
6		C				
7		C				
8		C				
9		C				
10		C				
11		C				
12		C				
13		C				
14	TO RECLASS HHA THERAPY COSTS	D				
15		D				
16	TO RECLASS RT SALARIES	E	RESPIRATORY THERAPY	49	11223	
17		E				
18		E				
19	TO RECLASS A&G EXPENSES	F	ADMINISTRATIVE & GENERAL	6	56318	11888
20		F				
21	TO RECLASS RHC PHYSICIAN RECRUITMEN	H	RHC	63.50		125645
22	TO RECLASS PROPERTY INSURANCE	I	NEW CAP REL COSTS-BLDG & FIXT	3		2147
23		I	NEW CAP REL COSTS-MVBLE EQUIP	4		30616
24		I	NEW CAP REL COSTS-MVBLE EQUIP	4.01		1360
25	EMPLOYEE BENEFIT RECLASS	J	EMPLOYEE BENEFITS	5	2857933	
26		J				
27		J				
28		J				
29		J				
30		J				
31		J				
32		J				
33		J				
34		J				
35		J				
36	SUBTOTAL				2925474	725676

RECLASSIFICATIONS

WORKSHEET A-6
 PAGE 1

EXPLANATION OF RECLASSIFICATION ENTRY		CODE	COST CENTER	DECREASE LINE #	SALARY	OTHER	WKST A-7 REF.
		1	6	7	8	9	10
1	TO RECLASS INTEREST EXPENSE	A	INTEREST EXPENSE	88		67500	11 1
2	TO RECLASS MEDICAL SUPPLIES	C					2
3		C					3
4		C	ADULTS & PEDIATRICS	25		6012	4
5		C	OPERATING ROOM	37		292798	5
6		C	ANESTHESIOLOGY	40		11935	6
7		C	RADIOLOGY-DIAGNOSTIC	41		114938	7
8		C	RESPIRATORY THERAPY	49		22157	8
9		C	PHYSICAL THERAPY	50		3617	9
10		C	OCCUPATIONAL THERAPY	51		414	10
11		C	EMERGENCY	61		4126	11
12		C	RHC	63.50		417	12
13		C	PHYSICIANS' PRIVATE OFFICES	98		30107	13
14	TO RECLASS HHA THERAPY COSTS	D					14
15		D					15
16	TO RECLASS RT SALARIES	E	ADULTS & PEDIATRICS	25	10779		16
17		E	ELECTROCARDIOLOGY	53	444		17
18		E					18
19	TO RECLASS A&G EXPENSES	F					19
20		F	PHYSICIANS' PRIVATE OFFICES	98	56318	11888	20
21	TO RECLASS RHC PHYSICIAN RECRUITM	H	ADMINISTRATIVE & GENERAL	6		125645	21
22	TO RECLASS PROPERTY INSURANCE	I	ADMINISTRATIVE & GENERAL	6		34122	11 22
23		I					11 23
24		I					11 24
25	EMPLOYEE BENEFIT RECLASS	J	EMPLOYEE BENEFITS	5		68559	25
26		J	ADMINISTRATIVE & GENERAL	6		466647	26
27		J	OPERATION OF PLANT	8		201715	27
28		J	HOUSEKEEPING	10		132152	28
29		J	DIETARY	11		140505	29
30		J	MEDICAL RECORDS & LIBRARY	17		27490	30
31		J	ADULTS & PEDIATRICS	25		251421	31
32		J	SKILLED NURSING FACILITY	34		247377	32
33		J	OPERATING ROOM	37		95782	33
34		J	ANESTHESIOLOGY	40		67507	34
35		J	RADIOLOGY-DIAGNOSTIC	41		121385	35
36	SUBTOTAL				67541	2546216	36

PROVIDER NO. 14-1318 OSF HOLY FAMILY MEDICAL CENTER
PERIOD FROM 10/01/2008 TO 09/30/2009

KPMG LLP COMPU-MAX MICRO SYSTEM
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RECLASSIFICATIONS

WORKSHEET A-6
PAGE 2

EXPLANATION OF RECLASSIFICATION ENTRY	CODE	----- INCREASE -----		
		COST CENTER	LINE #	SALARY OTHER
	1	2	3	4 5
1	J			1
2	J			2
3	J			3
4	J			4
5	J			5
6	J			6
7	J			7
8	J			8
9	J			9
10	J			10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36 TOTAL RECLASSIFICATIONS				2925474 725676 36

RECLASSIFICATIONS

WORKSHEET A-6
 PAGE 2

EXPLANATION OF RECLASSIFICATION ENTRY	CODE	COST CENTER	DECREASE LINE #	SALARY	OTHER	WKST A-7 REF.
	1	6	7	8	9	10
1	J	RADIOLOGY-DIAGNOSTIC	41		19444	1
2	J	LABORATORY	44		99861	2
3	J	PHYSICAL THERAPY	50		72326	3
4	J	OCCUPATIONAL THERAPY	51		14765	4
5	J	ELECTROCARDIOLOGY	53		44106	5
6	J	RESPIRATORY THERAPY	49		2374	6
7	J	DRUGS CHARGED TO PATIENTS	56		51625	7
8	J	EMERGENCY	61		105107	8
9	J	RHC	63.50		539452	9
10	J	PHYSICIANS' PRIVATE OFFICES	98		88333	10
11						11
12						12
13						13
14						14
15						15
16						16
17						17
18						18
19						19
20						20
21						21
22						22
23						23
24						24
25						25
26						26
27						27
28						28
29						29
30						30
31						31
32						32
33						33
34						34
35						35
36 TOTAL RECLASSIFICATIONS				67541	3583609	36

ANALYSIS OF CHANGES DURING COST REPORTING
 PERIOD IN CAPITAL ASSET BALANCES OF HOSPITAL
 AND HOSPITAL HEALTH CARE COMPLEX CERTIFIED
 TO PARTICIPATE IN HEALTH CARE PROGRAMS

WORKSHEET A-7
 PARTS I & II

PART I - ANALYSIS OF CHANGES IN OLD CAPITAL ASSET BALANCES

DESCRIPTION	BEGINNING BALANCES 1	----- ACQUISITIONS -----			DISPOSALS AND RETIREMENTS 5	ENDING BALANCE 6	FULLY DEPRECIATED ASSETS 7	
		PURCHASE 2	DONATION 3	TOTAL 4				
1 LAND								1
2 LAND IMPROVEMENTS								2
3 BUILDINGS AND FIXTURES								3
4 BUILDING IMPROVEMENTS								4
5 FIXED EQUIPMENT								5
6 MOVABLE EQUIPMENT								6
7 SUBTOTAL								7
8 RECONCILING ITEMS								8
9 TOTAL								9

PART II - ANALYSIS OF CHANGES IN NEW CAPITAL ASSET BALANCES

DESCRIPTION	BEGINNING BALANCES 1	----- ACQUISITIONS -----			DISPOSALS AND RETIREMENTS 5	ENDING BALANCE 6	FULLY DEPRECIATED ASSETS 7	
		PURCHASE 2	DONATION 3	TOTAL 4				
1 LAND	325000					325000		1
2 LAND IMPROVEMENTS	105423					105423		2
3 BUILDINGS AND FIXTURES	1777336	1100787		1100787		2878123		3
4 BUILDING IMPROVEMENTS								4
5 FIXED EQUIPMENT								5
6 MOVABLE EQUIPMENT	1600324	242843		242843		1843167		6
7 SUBTOTAL	3808083	1343630		1343630		5151713		7
8 RECONCILING ITEMS								8
9 TOTAL	3808083	1343630		1343630		5151713		9

PART III - RECONCILIATION OF CAPITAL COST CENTERS

WORKSHEET A-7
 PARTS III & IV

		----- COMPUTATION OF RATIOS -----			----- ALLOCATION OF OTHER CAPITAL -----			
DESCRIPTION		GROSS ASSETS	CAPITALIZED LEASES	GROSS ASSETS FOR RATIO	RATIO	INSURANCE	TAXES	OTHER CAPITAL- RELATED COSTS
		1	2	3	4	5	6	7
1	OLD CAP REL COSTS-BLDG & FIXT				.000000			
2	OLD CAP REL COSTS-MVBLE EQUIP				.000000			
3	NEW CAP REL COSTS-BLDG & FIXT	3308547		3308547	.642223			
4	NEW CAP REL COSTS-MVBLE EQUIP	1843167		1843167	.357777			
4.01	NEW CAP REL COSTS-MVBLE EQUIP N				.000000			
5	TOTAL	5151714		5151714	1.000000			

		----- SUMMARY OF OLD AND NEW CAPITAL -----						
DESCRIPTION		DEPREC- IATION	LEASE	INTEREST	INSURANCE	TAXES	OTHER CAPITAL- RELATED COSTS	TOTAL
		9	10	11	12	13	14	15
1	OLD CAP REL COSTS-BLDG & FIXT							1
2	OLD CAP REL COSTS-MVBLE EQUIP							2
3	NEW CAP REL COSTS-BLDG & FIXT	67492		2147				69639 3
4	NEW CAP REL COSTS-MVBLE EQUIP	962374		90332				1052706 4
4.01	NEW CAP REL COSTS-MVBLE EQUIP NH	42742		1360				44102 4.01
5	TOTAL	1072608		93839				1166447 5

PART IV - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 THRU 4

		----- SUMMARY OF OLD AND NEW CAPITAL -----						
DESCRIPTION		DEPREC- IATION	LEASE	INTEREST	INSURANCE	TAXES	OTHER CAPITAL- RELATED COSTS	TOTAL
		9	10	11	12	13	14	15
1	OLD CAP REL COSTS-BLDG & FIXT							1
2	OLD CAP REL COSTS-MVBLE EQUIP							2
3	NEW CAP REL COSTS-BLDG & FIXT	67492						67492 3
4	NEW CAP REL COSTS-MVBLE EQUIP	962374						962374 4
4.01	NEW CAP REL COSTS-MVBLE EQUIP NH	42742						42742 4.01
5	TOTAL	1072608						1072608 5

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ADJUSTMENTS TO EXPENSES

			EXPENSE CLASSIFICATION ON WORKSHEET A TO/ FROM WHICH THE AMOUNT IS TO BE ADJUSTED		WORKSHEET A-8	
DESCRIPTION	BASIS	AMOUNT	COST CENTER	LINE NO.	WKST A-7	REF
	1	2	3	4		5
1 INVESTMENT INCOME-OLD BLDGS & FIXTURES			OLD CAP REL COSTS-BLDG & FIXT	1		1
2 INVESTMENT INCOME-OLD MOVABLE EQUIPMENT			OLD CAP REL COSTS-MVBLE EQUIP	2		2
3 INVESTMENT INCOME-NEW BLDGS & FIXTURES			NEW CAP REL COSTS-BLDG & FIXT	3		3
4 INVESTMENT INCOME-NEW MOVABLE EQUIPMENT	B	-7784	NEW CAP REL COSTS-MVBLE EQUIP	4	11	4
5 INVESTMENT INCOME-OTHER						5
6 TRADE, QUANTITY, AND TIME DISCOUNTS						6
7 REFUNDS AND REBATES OF EXPENSES						7
8 RENTAL OF PROVIDER SPACE BY SUPPLIERS						8
9 TELEPHONE SERVICES (PAY STATIONS EXCL)	A	-4071	ADMINISTRATIVE & GENERAL	6		9
10 TELEVISION AND RADIO SERVICE	A	-1631	ADMINISTRATIVE & GENERAL	6		10
11 PARKING LOT						11
12 PROVIDER-BASED PHYSICIAN ADJUSTMENT	WKST					
	A-8-2	-256788				12
13 SALE OF SCRAP, WASTE, ETC.						13
14 RELATED ORGANIZATION TRANSACTIONS	WKST					
	A-8-1	1359423				14
15 LAUNDRY AND LINEN SERVICE						15
16 CAFETERIA - EMPLOYEES AND GUESTS	B	-38857	DIETARY	11		16
17 RENTAL OF QUARTERS TO EMPLOYEES & OTHERS						17
18 SALE OF MEDICAL AND SURGICAL SUPPLIES TO OTHER THAN PATIENTS						18
19 SALE OF DRUGS TO OTHER THAN PATIENTS						19
20 SALE OF MEDICAL RECORDS AND ABSTRACTS	B	-6204	MEDICAL RECORDS & LIBRARY	17		20
21 NURSING SCHOOL (TUITION, FEES, BOOKS, ETC.)						21
22 VENDING MACHINES						22
23 INCOME FROM IMPOSITION OF INTEREST, FINANCE OR PENALTY CHARGES						23
24 INTEREST EXP ON MEDICARE OVERPAYMENTS & BORROWINGS TO REPAY MEDICARE OVERPAYMENT						24
25 ADJ FOR RESPIRATORY THERAPY COSTS IN EXCESS OF LIMITATION - HOSPITAL	WKST		RESPIRATORY THERAPY	49		25
	A-8-4					
26 ADJ FOR PHYSICAL THERAPY COSTS IN EXCESS OF LIMITATION - HOSPITAL	WKST	-3917	PHYSICAL THERAPY	50		26
	A-8-4					
27 ADJ FOR HHA PHYSICAL THERAPY COSTS IN EXCESS OF LIMITATION	WKST		HOME HEALTH AGENCY	71		27
	A-8-3		UTILIZATION REVIEW-SNF	89		28
28 UTIL REVIEW-PHYSICIANS' COMPENSATION			OLD CAP REL COSTS-BLDG & FIXT	1		29
29 DEPRECIATION--OLD BUILDINGS & FIXTURES			OLD CAP REL COSTS-MVBLE EQUIP	2		30
30 DEPRECIATION--OLD MOVABLE EQUIPMENT			NEW CAP REL COSTS-BLDG & FIXT	3		31
31 DEPRECIATION--NEW BUILDINGS & FIXTURES			NEW CAP REL COSTS-MVBLE EQUIP	4		32
32 DEPRECIATION--NEW MOVABLE EQUIPMENT			NONPHYSICIAN ANESTHETISTS	20		33
33 NON-PHYSICIAN ANESTHETIST						34
34 PHYSICIANS' ASSISTANT						
35 ADJ FOR OCCUPATIONAL THERAPY COSTS IN EXCESS OF LIMITATION - HOSPITAL	WKST					35
	WKST A-8-4					
36 ADJ FOR SPEECH PATHOLOGY COSTS IN EXCESS OF LIMITATION - HOSPITAL	WKST		SPEECH PATHOLOGY	52		36
	WKST A-8-4					
37 MARKETING & DEVELOPMENT SALARIES	A	-67096	ADMINISTRATIVE & GENERAL	6		37
38 MARKETING & DEVELOPMENT FRINGE BE	A	-17301	ADMINISTRATIVE & GENERAL	6		38
39 MARKETING & DEVELOPMENT OTHER EXP	A	-66277	ADMINISTRATIVE & GENERAL	6		39
40 MARKETING & DEVELOPMENT OTHER EXP	A	-1676	DIETARY	11		40
41 ADVERTISING EXPENSE	A	-209178	ADMINISTRATIVE & GENERAL	6		41
42 MISCELLANEOUS INCOME	B	-2660	DIETARY	11		42
42.10 MISCELLANEOUS INCOME ADD	B	-3165	ADMINISTRATIVE & GENERAL	6		42.10
43 LOBBYING	A	-12360	ADMINISTRATIVE & GENERAL	6		43
44 PHYSICIAN RECRUITMENT	A	-23750	ADMINISTRATIVE & GENERAL	6		44
45 PUBLICATIONS & DUES	A	-58308	ADMINISTRATIVE & GENERAL	6		45
46 GAIN OF SALE	A	-122	ADMINISTRATIVE & GENERAL	6		46
47 CRNA PROFESSIONAL FEES	A	-4904	ANESTHESIOLOGY	40		47
48 PROVIDER TAX IDPA	A	-230665	ADMINISTRATIVE & GENERAL	6		48
49 CRNA SALARIES	A	-291423	ANESTHESIOLOGY	40		49
49.01 CRNA BENEFITS	A	-72015	EMPLOYEE BENEFITS	5		49.01
49.03 PROPERTY TAXES	A	-4800	ADMINISTRATIVE & GENERAL	6		49.03
49.04 RHC OTHER INCOME	B	-20031	RHC	63.50		49.04
49.05 ER BENEFITS	A	-33467	EMERGENCY	61		49.05
49.06 MISCELLANEOUS INCOME	B	-144	PHYSICAL THERAPY	50		49.06
49.07 ALCOHOLIC BEVERAGES	A	-1196	ADMINISTRATIVE & GENERAL	6		49.07
49.10 GOODWILL	A	-401167	INTEREST EXPENSE	88		49.10
50 TOTAL		-481534				50

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS

WORKSHEET A-8-1

A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR THE CLAIMING OF HOME OFFICE COSTS:

LINE NO.	COST CENTER	EXPENSE ITEMS	AMOUNT OF ALLOWABLE COST	AMOUNT (INCL IN WKST A, COL 5)	NET ADJUSTMENTS	WKST A-7 REF	
1	2	3	4	5	6	7	
1	6	ADMINISTRATIVE & GENERAL	A&G	1391846	495125	896721	1
2	6	ADMINISTRATIVE & GENERAL	INTEREST EXP CORP OFFICE	462702		462702	2
3	41	RADIOLOGY-DIAGNOSTIC	MOBILE MRI	171618	171618		3
4	41	RADIOLOGY-DIAGNOSTIC	ET MAINTENANCE AGREEMENT	140000	140000		4
5		TOTALS		2166166	806743	1359423	

B. INTERRELATIONSHIP OF RELATED ORGANIZATION(S) AND/OR HOME OFFICE:

THE SECRETARY, BY VIRTUE OF AUTHORITY GRANTED UNDER SECTION 1914(b)(1) OF THE SOCIAL SECURITY ACT, REQUIRES THAT YOU FURNISH THE INFORMATION REQUESTED UNDER PART B OF THIS WORKSHEET.

THE INFORMATION IS USED BY THE HEALTH CARE FINANCING ADMINISTRATION AND ITS INTERMEDIARIES IN DETERMINING THAT THE COSTS APPLICABLE TO SERVICES, FACILITIES, AND SUPPLIES FURNISHED BY ORGANIZATIONS RELATED TO YOU BY COMMON OWNERSHIP OR CONTROL REPRESENT REASONABLE COSTS AS DETERMINED UNDER SECTION 1861 OF THE SOCIAL SECURITY ACT. IF YOU DO NOT PROVIDE ALL OR ANY PART OF THE REQUESTED INFORMATION, THE COST REPORT IS CONSIDERED INCOMPLETE AND NOT ACCEPTABLE FOR PURPOSES OF CLAIMING REIMBURSEMENT UNDER TITLE XVIII.

----- RELATED ORGANIZATION(S) AND/OR HOME OFFICE -----

SYMBOL		NAME	PERCENT OF OWNERSHIP	NAME	PERCENT OF OWNERSHIP	TYPE OF BUSINESS
1	2	3	4	5	6	
1	B	OSF HEALTHCARE SYSTEM	100.00			
2						
3						
4						
5						

(1) USE THE FOLLOWING SYMBOLS TO INDICATE THE INTERRELATIONSHIP TO RELATED ORGANIZATIONS:

- INDIVIDUAL HAS FINANCIAL INTEREST (STOCKHOLDER, PARTNER, ETC.) IN BOTH RELATED ORGANIZATION AND IN PROVIDER.
- CORPORATION, PARTNERSHIP, OR OTHER ORGANIZATION HAS FINANCIAL INTEREST IN PROVIDER.
- PROVIDER HAS FINANCIAL INTEREST IN CORPORATION, PARTNERSHIP, OR OTHER ORGANIZATION.
- DIRECTOR, OFFICER, ADMINISTRATOR, OR KEY PERSON OF PROVIDER OR RELATIVE OF SUCH PERSON HAS FINANCIAL INTEREST IN RELATED ORGANIZATION.
- INDIVIDUAL IS DIRECTOR, OFFICER, ADMINISTRATOR, OR KEY PERSON OF PROVIDER AND RELATED ORGANIZATION.
- DIRECTOR, OFFICER, ADMINISTRATOR, OR KEY PERSON OF RELATED ORGANIZATION OR RELATIVE OF SUCH PERSON HAS FINANCIAL INTEREST IN PROVIDER.
- OTHER (FINANCIAL OR NON-FINANCIAL) SPECIFY:

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PROVIDER-BASED PHYSICIAN ADJUSTMENTS

WORKSHEET A-H-2

WKST A	COST CENTER/ PHYSICIAN IDENTIFIER	TOTAL REMUNERA- TION INCL FRINGES	PROFES- SIONAL COMPONENT	PROVIDER COMPONENT	RCE AMOUNT	PHYSICIAN/ PROVIDER COMPONENT HOURS	UNAD- JUSTED RCE LIMIT	PERCENT OF UNAD- JUSTED RCE LIMIT
1	2	3	4	5	6	7	8	9
1	61 EMERGENCY	376121	240688	135433				
2	44 LABORATORY	16100	16100					
101	TOTAL	392221	256788	135433				

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REASONABLE COST DETERMINATION FOR THERAPY SERVICES
FURNISHED BY OUTSIDE SUPPLIERS ON OR AFTER APRIL 10, 1998

WORKSHEET A-8-4
PARTS I & II

[] OCCUPATIONAL [XX] PHYSICAL [] RESPIRATORY [] SPEECH PATHOLOGY

PART I - GENERAL INFORMATION

1	TOTAL NUMBER OF WEEKS WORKED (EXCLUDING AIDES)				23	1
2	LINE 1 MULTIPLIED BY 15 HOURS PER WEEK				345	2
3	NUMBER OF UNDUPLICATED DAYS ON WHICH SUPERVISOR OR THERAPIST WAS ON PROVIDER SITE				113	3
4	NUMBER OF UNDUPLICATED DAYS ON WHICH THERAPY ASSISTANT WAS ON PROVIDER SITE BUT NEITHER SUPERVISOR NOR THERAPIST WAS ON PROVIDER SITE					4
5	NUMBER OF UNDUPLICATED OFFSITE VISITS - SUPERVISORS OR THERAPISTS					5
6	NUMBER OF UNDUPLICATED OFFSITE VISITS - THERAPY ASSISTANTS					6
7	STANDARD TRAVEL EXPENSE RATE				3.45	7
8	OPTIONAL TRAVEL EXPENSE RATE PER MILE					8
		SUPERVISORS	THERAPISTS	ASSISTANTS	AIDES	TRAINEES
		1	2	3	4	5
9	TOTAL HOURS WORKED		862.00			9
10	AHSEA		68.59			10
11	STANDARD TRAVEL ALLOWANCE	34.30	34.30			11
12	NO OF TRAVEL HRS (PROV SITE)					12
12.01	NO OF TRAVEL HRS (OFFSITE)					12.01
13	MILES DRIVEN (PROV SITE)					13
13.01	MILES DRIVEN (OFFSITE)					13.01

PART II - SALARY EQUIVALENCY COMPUTATION

14	SUPERVISORS					14
15	THERAPISTS				59125	15
16	ASSISTANTS					16
17	SUBTOTAL ALLOWANCE AMOUNT				59125	17
18	AIDES					18
19	TRAINEES					19
20	TOTAL ALLOWANCE AMOUNT				59125	20
21	WEIGHTED AVERAGE RATE EXCLUDING AIDES AND TRAINEES					21
22	WEIGHTED ALLOWANCE EXCLUDING AIDES AND TRAINEES					22
23	TOTAL SALARY EQUIVALENCY				59125	23

PROVIDER NO. 14-1318 OSF HOLY FAMILY MEDICAL CENTER
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REASONABLE COST DETERMINATION FOR THERAPY SERVICES
FURNISHED BY OUTSIDE SUPPLIERS ON OR AFTER APRIL 10, 1998

WORKSHEET A-8-4
PARTS III & IV

[] OCCUPATIONAL [XX] PHYSICAL [] RESPIRATORY [] SPEECH PATHOLOGY

PART III - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - PROVIDER SITE

24	STANDARD TRAVEL ALLOWANCE		
24	THERAPISTS	3876	24
25	ASSISTANTS		25
26	SUBTOTAL	3876	26
27	STANDARD TRAVEL EXPENSE	390	27
28	TOTAL STANDARD TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE AT THE PROVIDER SITE	4266	28
OPTIONAL TRAVEL ALLOWANCE AND OPTIONAL TRAVEL EXPENSE			
29	THERAPISTS		29
30	ASSISTANTS		30
31	SUBTOTAL		31
32	OPTIONAL TRAVEL EXPENSE		32
33	STANDARD TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE	4266	33
34	OPTIONAL TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE		34
35	OPTIONAL TRAVEL ALLOWANCE AND OPTIONAL TRAVEL EXPENSE		35

PART IV - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - SERVICES OUTSIDE PROVIDER SITE

STANDARD TRAVEL EXPENSE			
36	THERAPISTS		36
37	ASSISTANTS		37
38	SUBTOTAL		38
39	STANDARD TRAVEL EXPENSE		39
OPTIONAL TRAVEL ALLOWANCE AND OPTIONAL TRAVEL EXPENSE			
40	THERAPISTS		40
41	ASSISTANTS		41
42	SUBTOTAL		42
43	OPTIONAL TRAVEL EXPENSE		43
TOTAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE - OFFSITE SERVICES			
44	STANDARD TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE		44
45	OPTIONAL TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE		45
46	OPTIONAL TRAVEL ALLOWANCE AND OPTIONAL TRAVEL EXPENSE		46

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REASONABLE COST DETERMINATION FOR THERAPY SERVICES
FURNISHED BY OUTSIDE SUPPLIERS ON OR AFTER APRIL 10, 1998

WORKSHEET A-X-4
PARTS V, VI & VII

[] OCCUPATIONAL [XX] PHYSICAL [] RESPIRATORY [] SPEECH PATHOLOGY

PART V - OVERTIME COMPUTATION

	THERAPISTS 1	ASSISTANTS 2	AIDES 3	TRAINEES 4	TOTAL 5	
47						47
48						48
49						49
50						50
51						51
52						52
53						53
54						54
55						55
56						56

PART VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT

57					59125	57
58					4266	58
59						59
60						60
61						61
62						62
63					63391	63
64					67308	64
65					3917	65

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REASONABLE COST DETERMINATION FOR THERAPY SERVICES
FURNISHED BY OUTSIDE SUPPLIERS ON OR AFTER APRIL 10, 199*

WORKSHEET A-4-4
PARTS V, VI & VII

[] OCCUPATIONAL [XX] PHYSICAL [] RESPIRATORY [] SPEECH PATHOLOGY

PART VII - ALLOCATION OF THERAPY EXCESS COST OVER LIMITATION FOR NONSHARED THERAPY DEPARTMENT SERVICES

66	COST OF OUTSIDE SUPPLIER SERVICES - HOSPITAL	67308	66
67	TOTAL COST	67308	67
68	RATIO OF COST OF OUTSIDE SUPPLIER SERVICES TO TOTAL COST - HOSPITAL	1.000000	68
69	EXCESS OF COST OVER LIMITATION - HOSPITAL	3917	69
70	TOTAL EXCESS OF COST OVER LIMITATION	3917	70

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REASONABLE COST DETERMINATION FOR THERAPY SERVICES
FURNISHED BY OUTSIDE SUPPLIERS ON OR AFTER APRIL 10, 1998

WORKSHEET A-8-4
PARTS I & II

[] OCCUPATIONAL [] PHYSICAL [] RESPIRATORY [XX] SPEECH PATHOLOGY

PART I - GENERAL INFORMATION

1	TOTAL NUMBER OF WEEKS WORKED (EXCLUDING AIDES)					19	1
2	LINE 1 MULTIPLIED BY 15 HOURS PER WEEK					285	2
3	NUMBER OF UNDUPLICATED DAYS ON WHICH SUPERVISOR OR THERAPIST WAS ON PROVIDER SITE					97	3
4	NUMBER OF UNDUPLICATED DAYS ON WHICH THERAPY ASSISTANT WAS ON PROVIDER SITE BUT NEITHER SUPERVISOR NOR THERAPIST WAS ON PROVIDER SITE						4
5	NUMBER OF UNDUPLICATED OFFSITE VISITS - SUPERVISORS OR THERAPISTS						5
6	NUMBER OF UNDUPLICATED OFFSITE VISITS - THERAPY ASSISTANTS						6
7	STANDARD TRAVEL EXPENSE RATE					3.45	7
8	OPTIONAL TRAVEL EXPENSE RATE PER MILE						8
		SUPERVISORS	THERAPISTS	ASSISTANTS	AIDES	TRAINEES	
		1	2	3	4	5	
9	TOTAL HOURS WORKED		147.00				9
10	AHSEA		62.49				10
11	STANDARD TRAVEL ALLOWANCE	31.25	31.25				11
12	NO OF TRAVEL HRS (PROV SITE)						12
12.01	NO OF TRAVEL HRS (OFFSITE)						12.01
13	MILES DRIVEN (PROV SITE)						13
13.01	MILES DRIVEN (OFFSITE)						13.01

PART II - SALARY EQUIVALENCY COMPUTATION

14	SUPERVISORS						14
15	THERAPISTS					9186	15
16	ASSISTANTS						16
17	SUBTOTAL ALLOWANCE AMOUNT					9186	17
18	AIDES						18
19	TRAINEES						19
20	TOTAL ALLOWANCE AMOUNT					9186	20
21	WEIGHTED AVERAGE RATE EXCLUDING AIDES AND TRAINEES					62.49	21
22	WEIGHTED ALLOWANCE EXCLUDING AIDES AND TRAINEES					17810	22
23	TOTAL SALARY EQUIVALENCY					17810	23

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REASONABLE COST DETERMINATION FOR THERAPY SERVICES
FURNISHED BY OUTSIDE SUPPLIERS ON OR AFTER APRIL 10, 1998

WORKSHEET A-8-4
PARTS III & IV

[] OCCUPATIONAL [] PHYSICAL [] RESPIRATORY [XX] SPEECH PATHOLOGY

PART III - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - PROVIDER SITE

STANDARD TRAVEL ALLOWANCE		
24 THERAPISTS	3031	24
25 ASSISTANTS		25
26 SUBTOTAL	3031	26
27 STANDARD TRAVEL EXPENSE	335	27
28 TOTAL STANDARD TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE AT THE PROVIDER SITE	3366	28
OPTIONAL TRAVEL ALLOWANCE AND OPTIONAL TRAVEL EXPENSE		
29 THERAPISTS		29
30 ASSISTANTS		30
31 SUBTOTAL		31
32 OPTIONAL TRAVEL EXPENSE		32
33 STANDARD TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE	3366	33
34 OPTIONAL TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE		34
35 OPTIONAL TRAVEL ALLOWANCE AND OPTIONAL TRAVEL EXPENSE		35

PART IV - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - SERVICES OUTSIDE PROVIDER SITE

STANDARD TRAVEL EXPENSE		
36 THERAPISTS		36
37 ASSISTANTS		37
38 SUBTOTAL		38
39 STANDARD TRAVEL EXPENSE		39
OPTIONAL TRAVEL ALLOWANCE AND OPTIONAL TRAVEL EXPENSE		
40 THERAPISTS		40
41 ASSISTANTS		41
42 SUBTOTAL		42
43 OPTIONAL TRAVEL EXPENSE		43
TOTAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE - OFFSITE SERVICES		
44 STANDARD TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE		44
45 OPTIONAL TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE		45
46 OPTIONAL TRAVEL ALLOWANCE AND OPTIONAL TRAVEL EXPENSE		46

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REASONABLE COST DETERMINATION FOR THERAPY SERVICES
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WORKSHEET A-4-4
 PARTS V, VI & VII

[] OCCUPATIONAL [] PHYSICAL [] RESPIRATORY [XX] SPEECH PATHOLOGY

PART V - OVERTIME COMPUTATION

	THERAPISTS 1	ASSISTANTS 2	AIDES 3	TRAINEES 4	TOTAL 5	
47	OVERTIME HOURS WORKED					47
48	DURING REPORTING PERIOD					
48	OVERTIME RATE					48
49	TOTAL OVERTIME					49
50	CALCULATION OF LIMIT					
50	PERCENTAGE OF OVERTIME					50
51	HOURS BY CATEGORY					
51	ALLOCATION OF PROVIDER'S					51
51	STANDARD WORKYEAR FOR ONE					
51	FULL TIME EMPLOYEE TIMES					
51	THE PERCENTAGES ON LINE 50					
52	DETERMINATION OF OVERTIME ALLOWANCE					
52	ADJUSTED HOURLY SALARY					52
53	EQUIVALENCY AMOUNT					
53	OVERTIME COST LIMITATION					53
54	MAXIMUM OVERTIME COST					54
55	PORTION OF OVERTIME ALREADY					55
55	INCLUDED IN HOURLY					
56	COMPUTATION AT THE AHSEA					
56	OVERTIME ALLOWANCE					56

PART VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT

57	SALARY EQUIVALENCY AMOUNT	17610	57
58	TRAVEL ALLOWANCE AND EXPENSE - PROVIDER SITE	3366	58
59	TRAVEL ALLOWANCE AND EXPENSE - OFFSITE SERVICES		59
60	OVERTIME ALLOWANCE		60
61	EQUIPMENT COST		61
62	SUPPLIES		62
63	TOTAL ALLOWANCE	21176	63
64	TOTAL COST OF OUTSIDE SUPPLIER SERVICES	8300	64
65	EXCESS OVER LIMITATION		65

PROVIDER NO. 14-1318 OSF HOLY FAMILY MEDICAL CENTER
PERIOD FROM 10/01/2008 TO 09/30/2009

KPMG LLP COMPU-MAX MICRO SYSTEM
IN LIEU OF FORM CMS-2552-06 (11/98)

VERSION: 2010.02
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REASONABLE COST DETERMINATION FOR THERAPY SERVICES
FURNISHED BY OUTSIDE SUPPLIERS ON OR AFTER APRIL 10, 1998

WORKSHEET A-8-4
PARTS V, VI & VII

[] OCCUPATIONAL [] PHYSICAL [] RESPIRATORY [XX] SPEECH PATHOLOGY

PART VII - ALLOCATION OF THERAPY EXCESS COST OVER LIMITATION FOR NONSHARED THERAPY DEPARTMENT SERVICES

66	COST OF OUTSIDE SUPPLIER SERVICES - HOSPITAL	8300	66
67	TOTAL COST	8300	67
68	RATIO OF COST OF OUTSIDE SUPPLIER SERVICES TO TOTAL COST - HOSPITAL	1.000000	68
69	EXCESS OF COST OVER LIMITATION - HOSPITAL	0	69
70	TOTAL EXCESS OF COST OVER LIMITATION	0	70

PROVIDER NO. 14-1318 OSF HOLY FAMILY MEDICAL CENTER
PERIOD FROM 10/01/2008 TO 09/30/2009

KPMG LLP COMPU-MAX MICRO SYSTEM
IN LIEU OF FORM CMS-2552-06 (9/90)

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COST ALLOCATION - GENERAL SERVICE COSTS

WORKSHEET B
PART I

COST CENTER DESCRIPTION		NET EXP FOR COST ALLOCATION 0	NEW CAP BLDGS & FIXTURES 3	NEW CAP MOVABLE EQUIPMENT 4	NEW CAP MOVABLE EQUIP NH 4.01	EMPLOYEE BENEFITS 5	SUBTOTAL 5A	ADMINIS- TRATIVE + GENERAL 6	OPERATION OF PLANT 8	
GENERAL SERVICE COST CENTERS										
1	OLD CAP REL COSTS-BLDG & FIXT									1
2	OLD CAP REL COSTS-MVBLE EQUIP									2
3	NEW CAP REL COSTS-BLDG & FIXT	69639	69639							3
4	NEW CAP REL COSTS-MVBLE EQUIP	1052706		1052706						4
4.01	NEW CAP REL COSTS-MVBLE EQUIP N	44102			44102					4.01
5	EMPLOYEE BENEFITS	2788514				2788514				5
6	ADMINISTRATIVE & GENERAL	4832638	6422	97080		508522	5444662	5444662		6
7	MAINTENANCE & REPAIRS									7
8	OPERATION OF PLANT	1277108	7935	119950		126119	1531112	491934	2023046	8
9	LAUNDRY & LINEN SERVICE	106424					106424	34193		9
10	HOUSEKEEPING	400654	696	10527		84647	496524	159529	25485	10
11	DIETARY	596920	4832	73037		84377	759166	243914	176812	11
12	CAFETERIA									12
13	MAINTENANCE OF PERSONNEL									13
14	NURSING ADMINISTRATION									14
15	CENTRAL SERVICES & SUPPLY									15
16	PHARMACY									16
17	MEDICAL RECORDS & LIBRARY	222869	1921	29036		45774	299600	96259	70291	17
18	SOCIAL SERVICE									18
20	NONPHYSICIAN ANESTHETISTS									20
21	NURSING SCHOOL									21
22	I&R SERVICES-SALARY & FRINGES A									22
23	I&R SERVICES-OTHER PRGM COSTS A									23
24	PARAMED ED PRGM-(SPECIFY)									24
INPATIENT ROUTINE SERV COST CENTERS										
25	ADULTS & PEDIATRICS	1067304	8133	122950		253920	1452307	466615	297643	25
34	SKILLED NURSING FACILITY	899716	9040	136622	44102	220502	1309982	420887	330738	34
ANCILLARY SERVICE COST CENTERS										
37	OPERATING ROOM	454239	3561	53831		87736	599367	192572	130318	37
38	RECOVERY ROOM									38
40	ANESTHESIOLOGY	10309	169	2557		1112	14147	4545	6190	40
41	RADIOLOGY-DIAGNOSTIC	1209591	3196	48319		102983	1364089	438271	116972	41
44	LABORATORY	1036642	1420	21464		94188	1153714	370679	51961	44
46.30	BLOOD CLOTTING FACTORS ADMIN CO									46.30
49	RESPIRATORY THERAPY	49266				9406	58672	18851		49
50	PHYSICAL THERAPY	343414	2378	35954		67526	449272	144347	87039	50
51	OCCUPATIONAL THERAPY	75187				18889	94076	30226		51
52	SPEECH PATHOLOGY	6990	26	387			7403	2379	938	52
53	ELECTROCARDIOLOGY	158015	1273	19250		36587	215125	69118	46601	53
55	MEDICAL SUPPLIES CHARGED TO PAT	423331	2583	39053		4730	469697	150910	94543	55
56	DRUGS CHARGED TO PATIENTS	759538	814	12298		64789	837439	269062	29772	56
59.97	CARDIAC REHABILITATION									59.97
59.98	HYPERBARIC OXYGEN THERAPY									59.98
59.99	LITHOTRIPSY									59.99
OUTPATIENT SERVICE COST CENTERS										
61	EMERGENCY	715311	3730	56388		172092	947521	304431	136508	61
62	OBSERVATION BEDS (NON-DISTINCT									62
63.50	RHC	2861350	6741	101907		593275	3563273	1144844	246701	63.50
63.60	FQHC									63.60
OTHER REIMBURSABLE COST CENTERS										
69.10	CMHC									69.10
69.20	OUTPATIENT PHYSICAL THERAPY									69.20
69.30	OUTPATIENT OCCUPATIONAL THERAPY									69.30
69.40	OUTPATIENT SPEECH PATHOLOGY									69.40
71	HOME HEALTH AGENCY									71
SPECIAL PURPOSE COST CENTERS										
85.01	PANCREAS ACQUISITION									85.01
85.02	INTESTINAL ACQUISITION									85.02
85.03	ISLET CELL ACQUISITION									85.03
95	SUBTOTALS	21461777	64870	980610	44102	2577174	21173572	5053566	1848512	95
NONREIMBURSABLE COST CENTERS										
98	PHYSICIANS' PRIVATE OFFICES	929054	4769	72096		211340	1217259	391096	174534	98
100	CLINIC									100
100.01	RENTAL SPACE									100.01
101	CROSS FOOT ADJUSTMENTS									101
102	NEGATIVE COST CENTER									102
103	TOTAL	22390831	69639	1052706	44102	2788514	22390831	5444662	2023046	103

COST ALLOCATION - GENERAL SERVICE COSTS

WORKSHEET B
 PART I

COST CENTER DESCRIPTION	LAUNDRY + LINEN SERVICE 9	HOUSE- KEEPING 10	DIETARY 11	CAFETERIA 12	MEDICAL RECORDS + LIBRARY 17	SUBTOTAL 25	I&R COST & POST STEP- DOWN ADJ'S 26	TOTAL 27
GENERAL SERVICE COST CENTERS								
1 OLD CAP REL COSTS-BLDG & FIXT								1
2 OLD CAP REL COSTS-MVBLE EQUIP								2
3 NEW CAP REL COSTS-BLDG & FIXT								3
4 NEW CAP REL COSTS-MVBLE EQUIP								4
4.01 NEW CAP REL COSTS-MVBLE EQUIP M								4.01
5 EMPLOYEE BENEFITS								5
6 ADMINISTRATIVE & GENERAL								6
7 MAINTENANCE & REPAIRS								7
8 OPERATION OF PLANT								8
9 LAUNDRY & LINEN SERVICE	140617							9
10 HOUSEKEEPING	20139	701676						10
11 DIETARY		62108	1242000					11
12 CAFETERIA			782418	782418				12
13 MAINTENANCE OF PERSONNEL								13
14 NURSING ADMINISTRATION								14
15 CENTRAL SERVICES & SUPPLY								15
16 PHARMACY								16
17 MEDICAL RECORDS & LIBRARY		24691		29723	520564			17
18 SOCIAL SERVICE								18
20 NONPHYSICIAN ANESTHETISTS								20
21 NURSING SCHOOL								21
22 I&R SERVICES-SALARY & FRINGES A								22
23 I&R SERVICES-OTHER PRGM COSTS A								23
24 PARAMED ED PRGM-(SPECIFY)								24
INPATIENT ROUTINE SERV COST CENTERS								
25 ADULTS & PEDIATRICS	29788	104552	128646	129094	29748	2638393	2638393	25
34 SKILLED NURSING FACILITY	48940	116178	330936	129621	13352	2700634	2700634	34
ANCILLARY SERVICE COST CENTERS								
37 OPERATING ROOM	9961	45776		24330	42875	1045199	1045199	37
38 RECOVERY ROOM				7328		7328	7328	38
40 ANESTHESIOLOGY		2174				27056	27056	40
41 RADIOLOGY-DIAGNOSTIC	8381	41088		48894	122308	2140003	2140003	41
44 LABORATORY	140	18252		59388	89616	1743750	1743750	44
46.30 BLOOD CLOTTING FACTORS ADMIN CO								46.30
49 RESPIRATORY THERAPY				3342	6753	87618	87618	49
50 PHYSICAL THERAPY	11610	30574		30309	29009	782160	782160	50
51 OCCUPATIONAL THERAPY				5452	4714	134468	134468	51
52 SPEECH PATHOLOGY		329			437	11486	11486	52
53 ELECTROCARDIOLOGY	257	16369		11667	4492	363629	363629	53
55 MEDICAL SUPPLIES CHARGED TO PAT		33210		2111	32677	783148	783148	55
56 DRUGS CHARGED TO PATIENTS		10458		18467	36815	1202013	1202013	56
59.97 CARDIAC REHABILITATION								59.97
59.98 HYPERBARIC OXYGEN THERAPY								59.98
59.99 LITHOTRIPSY								59.99
OUTPATIENT SERVICE COST CENTERS								
61 EMERGENCY	9418	47951		45552	42092	1533473	1533473	61
62 OBSERVATION BEDS (NON-DISTINCT								62
63.50 RHC	1347	86658		200030	42151	5285004	5285004	63.50
63.60 FQHC								63.60
OTHER REIMBURSABLE COST CENTERS								
69.10 CMHC								69.10
69.20 OUTPATIENT PHYSICAL THERAPY								69.20
69.30 OUTPATIENT OCCUPATIONAL THERAPY								69.30
69.40 OUTPATIENT SPEECH PATHOLOGY								69.40
71 HOME HEALTH AGENCY								71
SPECIAL PURPOSE COST CENTERS								
85.01 PANCREAS ACQUISITION								85.01
85.02 INTESTINAL ACQUISITION								85.02
85.03 ISLET CELL ACQUISITION								85.03
95 SUBTOTALS	139980	640368	1242000	745308	497039	20485362	20485362	95
NONREIMBURSABLE COST CENTERS								
98 PHYSICIANS' PRIVATE OFFICES	637	61308		37110	23525	1905469	1905469	98
100 CLINIC								100
100.01 RENTAL SPACE								100.01
101 CROSS FOOT ADJUSTMENTS								101
102 NEGATIVE COST CENTER								102
103 TOTAL	140617	701676	1242000	782418	520564	22390831	22390831	103

PROVIDER NO. 14-1318 OSF HOLY FAMILY MEDICAL CENTER
PERIOD FROM 10/01/2008 TO 09/30/2009

KPMG LLP COMPU-MAX MICRO SYSTEM
IN LIEU OF FORM CMS-2552-96 (4/96)

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ALLOCATION OF NEW CAPITAL RELATED COSTS

WORKSHEET B
PART III

COST CENTER DESCRIPTION		DIR ASSGND CAP-REL COSTS 0	NEW CAP BLDG & FIXTURES 3	NEW CAP MOVABLE EQUIPMENT 4	NEW CAP MOVABLE EQUIP NH 4.01	CAP REL COST TO BE ALLOC 4A	ADMINIS- TRATIVE + GENERAL 6	OPERATION OF PLANT 8	LAUNDRY + LINEN SERVICE 9	
1	GENERAL SERVICE COST CENTERS									1
2	OLD CAP REL COSTS-BLDG & FIXT									2
3	OLD CAP REL COSTS-MVBLE EQUIP									3
4	NEW CAP REL COSTS-BLDG & FIXT									4
4.01	NEW CAP REL COSTS-MVBLE EQUIP N									4.01
5	EMPLOYEE BENEFITS									5
6	ADMINISTRATIVE & GENERAL	241626	6422	97080		345128	345128			6
7	MAINTENANCE & REPAIRS									7
8	OPERATION OF PLANT		7935	119950		127885	31183	159068		8
9	LAUNDRY & LINEN SERVICE						2167		2167	9
10	HOUSEKEEPING		696	10527		11223	10112	2004	310	10
11	DIETARY		4832	73037		77869	15461	13902		11
12	CAFETERIA									12
13	MAINTENANCE OF PERSONNEL									13
14	NURSING ADMINISTRATION									14
15	CENTRAL SERVICES & SUPPLY									15
16	PHARMACY									16
17	MEDICAL RECORDS & LIBRARY		1921	29036		30957	6102	5527		17
18	SOCIAL SERVICE									18
20	NONPHYSICIAN ANESTHETISTS									20
21	NURSING SCHOOL									21
22	I&R SERVICES-SALARY & FRINGES A									22
23	I&R SERVICES-OTHER PRGM COSTS A									23
24	PARAMED ED PRGM-(SPECIFY)									24
	INPATIENT ROUTINE SERV COST CENTERS									
25	ADULTS & PEDIATRICS		8133	122950		131083	29578	23403	459	25
34	SKILLED NURSING FACILITY		9040	136622	44102	189764	26679	26004	754	34
	ANCILLARY SERVICE COST CENTERS									
37	OPERATING ROOM		3561	53831		57392	12207	10247	154	37
38	RECOVERY ROOM									38
40	ANESTHESIOLOGY		169	2557		2726	288	487		40
41	RADIOLOGY-DIAGNOSTIC		3196	48319		51515	27781	9197	129	41
44	LABORATORY		1420	21464		22884	23497	4086	2	44
46.30	BLOOD CLOTTING FACTORS ADMIN CO									46.30
49	RESPIRATORY THERAPY						1195			49
50	PHYSICAL THERAPY		2378	35954		38332	9150	6844	179	50
51	OCCUPATIONAL THERAPY						1916			51
52	SPEECH PATHOLOGY		26	387		413	151	74		52
53	ELECTROCARDIOLOGY		1273	19250		20523	4381	3664	4	53
55	MEDICAL SUPPLIES CHARGED TO PAT		2583	39053		41636	9566	7434		55
56	DRUGS CHARGED TO PATIENTS		814	12298		13112	17055	2341		56
59.97	CARDIAC REHABILITATION									59.97
59.98	HYPERBARIC OXYGEN THERAPY									59.98
59.99	LITHOTRIPSY									59.99
	OUTPATIENT SERVICE COST CENTERS									
61	EMERGENCY		3730	56388		60118	19297	10733	145	61
62	OBSERVATION BEDS (NON-DISTINCT									62
63.50	RHC		6741	101907		108648	72571	19398	21	63.50
63.60	FQHC									63.60
	OTHER REIMBURSABLE COST CENTERS									
69.10	CMHC									69.10
69.20	OUTPATIENT PHYSICAL THERAPY									69.20
69.30	OUTPATIENT OCCUPATIONAL THERAPY									69.30
69.40	OUTPATIENT SPEECH PATHOLOGY									69.40
71	HOME HEALTH AGENCY									71
	SPECIAL PURPOSE COST CENTERS									
85.01	PANCREAS ACQUISITION									85.01
85.02	INTESTINAL ACQUISITION									85.02
85.03	ISLET CELL ACQUISITION									85.03
95	SUBTOTALS	241626	64870	980610	44102	1331208	320337	145345	2157	95
	NONREIMBURSABLE COST CENTERS									
98	PHYSICIANS' PRIVATE OFFICES		4769	72096		76865	24791	13723	10	98
100	CLINIC									100
100.01	RENTAL SPACE									100.01
101	CROSS FOOT ADJUSTMENTS									101
102	NEGATIVE COST CENTER									102
103	TOTAL	241626	69639	1052706	44102	1408073	345128	159068	2167	103

ALLOCATION OF NEW CAPITAL RELATED COSTS

WORKSHEET B
 PART III

COST CENTER DESCRIPTION		HOUSE- KEEPING	DIETARY	CAFETERIA	MEDICAL RECORDS & LIBRARY	SUBTOTAL	I&R COST & POST STEP- DOWN ADJS	TOTAL	
		10	11	12	17	25	26	27	
GENERAL SERVICE COST CENTERS									
1	OLD CAP REL COSTS-BLDG & FIXT								1
2	OLD CAP REL COSTS-MVBLE EQUIP								2
3	NEW CAP REL COSTS-BLDG & FIXT								3
4	NEW CAP REL COSTS-MVBLE EQUIP								4
4.01	NEW CAP REL COSTS-MVBLE EQUIP N								4.01
5	EMPLOYEE BENEFITS								5
6	ADMINISTRATIVE & GENERAL								6
7	MAINTENANCE & REPAIRS								7
8	OPERATION OF PLANT								8
9	LAUNDRY & LINEN SERVICE								9
10	HOUSEKEEPING	23649							10
11	DIETARY	2093	109325						11
12	CAFETERIA		68871	68871					12
13	MAINTENANCE OF PERSONNEL								13
14	NURSING ADMINISTRATION								14
15	CENTRAL SERVICES & SUPPLY								15
16	PHARMACY								16
17	MEDICAL RECORDS & LIBRARY	832		2616	46034				17
18	SOCIAL SERVICE								18
20	NONPHYSICIAN ANESTHETISTS								20
21	NURSING SCHOOL								21
22	I&R SERVICES-SALARY & FRINGES A								22
23	I&R SERVICES-OTHER PRGM COSTS A								23
24	PARAMED ED PRGM-(SPECIFY)								24
INPATIENT ROUTINE SERV COST CENTERS									
25	ADULTS & PEDIATRICS	3524	11324	11363	2631	213365		213365	25
34	SKILLED NURSING FACILITY	3917	29130	11410	1181	288839		288839	34
ANCILLARY SERVICE COST CENTERS									
37	OPERATING ROOM	1543		2142	3792	87477		87477	37
38	RECOVERY ROOM			645		645		645	38
40	ANESTHESIOLOGY	73				3574		3574	40
41	RADIOLOGY-DIAGNOSTIC	1385		4304	10810	105121		105121	41
44	LABORATORY	615		5228	7926	64238		64238	44
46.30	BLOOD CLOTTING FACTORS ADMIN CO								46.30
49	RESPIRATORY THERAPY			294	597	2086		2086	49
50	PHYSICAL THERAPY	1030		2668	2566	60769		60769	50
51	OCCUPATIONAL THERAPY			480	417	2813		2813	51
52	SPEECH PATHOLOGY	11			39	688		688	52
53	ELECTROCARDIOLOGY	552		1027	397	30548		30548	53
55	MEDICAL SUPPLIES CHARGED TO PAT	1119		186	2890	62831		62831	55
56	DRUGS CHARGED TO PATIENTS	352		1626	3256	37742		37742	56
59.97	CARDIAC REHABILITATION								59.97
59.98	HYPERBARIC OXYGEN THERAPY								59.98
59.99	LITHOTRIPSY								59.99
OUTPATIENT SERVICE COST CENTERS									
61	EMERGENCY	1616		4010	3723	99642		99642	61
62	OBSERVATION BEDS (NON-DISTINCT								62
63.50	RHC	2921		17605	3728	224892		224892	63.50
63.60	FQHC								63.60
OTHER REIMBURSABLE COST CENTERS									
69.10	CMHC								69.10
69.20	OUTPATIENT PHYSICAL THERAPY								69.20
69.30	OUTPATIENT OCCUPATIONAL THERAPY								69.30
69.40	OUTPATIENT SPEECH PATHOLOGY								69.40
71	HOME HEALTH AGENCY								71
SPECIAL PURPOSE COST CENTERS									
85.01	PANCREAS ACQUISITION								85.01
85.02	INTESTINAL ACQUISITION								85.02
85.03	ISLET CELL ACQUISITION								85.03
95	SUBTOTALS	21583	109325	65604	43953	1285270		1285270	95
NONREIMBURSABLE COST CENTERS									
98	PHYSICIANS' PRIVATE OFFICES	2066		3267	2081	122803		122803	98
100	CLINIC								100
100.01	RENTAL SPACE								100.01
101	CROSS FOOT ADJUSTMENTS								101
102	NEGATIVE COST CENTER								102
103	TOTAL	23649	109325	68871	46034	1408073		1408073	103

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WORKSHEET B-1

COST CENTER DESCRIPTION	NEW CAP BLDG & FIXTURES SQUARE FEET	NEW CAP MOVABLE EQUIPMENT SQUARE FEET	NEW CAP MVBLE EQUIP NH SQUARE FEET	EMPLOYEE BENEFITS GROSS SALARIES	RECON- CILIATION	ADMINIS- TRATIVE + GENERAL ACCUM COST	OPERATION OF PLANT SQUARE FEET
	3	4	4.01	5	6A	6	8
GENERAL SERVICE COST CENTERS							
1 OLD CAP REL COSTS-BLDG & FIXT							1
2 OLD CAP REL COSTS-MVBLE EQUIP							2
3 NEW CAP REL COSTS-BLDG & FIXT	95049						3
4 NEW CAP REL COSTS-MVBLE EQUIP		95099					4
4.01 NEW CAP REL COSTS-MVBLE EQUIP			21548				4.01
5 EMPLOYEE BENEFITS				11050955			5
6 ADMINISTRATIVE & GENERAL	8770	8770		2015288	-5444662	16946169	6
7 MAINTENANCE & REPAIRS							7
8 OPERATION OF PLANT	10836	10836		499813		1531113	8
9 LAUNDRY & LINEN SERVICE						106424	9
10 HOUSEKEEPING	951	951		335457		496524	10
11 DIETARY	6598	6598		334390		759166	11
12 CAFETERIA							12
13 MAINTENANCE OF PERSONNEL							13
14 NURSING ADMINISTRATION							14
15 CENTRAL SERVICES & SUPPLY							15
16 PHARMACY							16
17 MEDICAL RECORDS & LIBRARY	2623	2623		181405		299600	17
18 SOCIAL SERVICE							18
20 NONPHYSICIAN ANESTHETISTS							20
21 NURSING SCHOOL							21
22 I&R SERVICES-SALARY & FRINGES							22
23 I&R SERVICES-OTHER PRGM COSTS							23
24 PARAMED ED PRGM-(SPECIFY)							24
INPATIENT ROUTINE SERV COST CENTERS							
25 ADULTS & PEDIATRICS	11107	11107		1006294		1452307	25
34 SKILLED NURSING FACILITY	12342	12342	21548	873855		1309982	34
ANCILLARY SERVICE COST CENTERS							
37 OPERATING ROOM	4863	4863		347699		599367	37
38 RECOVERY ROOM							38
40 ANESTHESIOLOGY	231	231		4406		14147	40
41 RADIOLOGY-DIAGNOSTIC	4365	4365		408126		1364089	41
44 LABORATORY	1939	1939		373272		1153714	44
46.30 BLOOD CLOTTING FACTORS ADMIN							46.30
49 RESPIRATORY THERAPY				37278		58672	49
50 PHYSICAL THERAPY	3248	3248		267607		449272	50
51 OCCUPATIONAL THERAPY				74857		94076	51
52 SPEECH PATHOLOGY	35	35				7403	52
53 ELECTROCARDIOLOGY	1739	1739		144996		215125	53
55 MEDICAL SUPPLIES CHARGED TO P	3528	3528		18747		469697	55
56 DRUGS CHARGED TO PATIENTS	1111	1111		256761		837439	56
59.97 CARDIAC REHABILITATION							59.97
59.98 HYPERBARIC OXYGEN THERAPY							59.98
59.99 LITHOTRIPSY							59.99
OUTPATIENT SERVICE COST CENTERS							
61 EMERGENCY	5094	5094		682008		947521	61
62 OBSERVATION BEDS (NON-DISTINC							62
63.50 RHC	9206	9206		2351149		3563273	63.50
63.60 FQHC							63.60
OTHER REIMBURSABLE COST CENTERS							
69.10 CMHC							69.10
69.20 OUTPATIENT PHYSICAL THERAPY							69.20
69.30 OUTPATIENT OCCUPATIONAL THERA							69.30
69.40 OUTPATIENT SPEECH PATHOLOGY							69.40
71 HOME HEALTH AGENCY							71
SPECIAL PURPOSE COST CENTERS							
85.01 PANCREAS ACQUISITION							85.01
85.02 INTESTINAL ACQUISITION							85.02
85.03 ISLET CELL ACQUISITION							85.03
95 SUBTOTALS	88586	88586	21548	10213408	-5444662	15728910	95
NONREIMBURSABLE COST CENTERS							
98 PHYSICIANS' PRIVATE OFFICES	6513	6513		837547		1217259	98
100 CLINIC							100

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WORKSHEET B-1

COST CENTER DESCRIPTION		LAUNDRY + LINEN SERVICE POUNDS OF LAUNDRY 9	HOUSE- KEEPING SQUARE FEET 10	DIETARY MEALS SERVED 11	CAFETERIA FTE'S 12	CENTRAL SERVICES + SUPPLY COSTED REQUIS. 15	PHARMACY COSTED REQUIS. 16	MEDICAL RECORDS + LIBRARY GROSS REVENUE 17	
GENERAL SERVICE COST CENTERS									
1	OLD CAP REL COSTS-BLDG & FIXT								1
2	OLD CAP REL COSTS-MVBLE EQUIP								2
3	NEW CAP REL COSTS-BLDG & FIXT								3
4	NEW CAP REL COSTS-MVBLE EQUIP								4
4.01	NEW CAP REL COSTS-MVBLE EQUIP								4.01
5	EMPLOYEE BENEFITS								5
6	ADMINISTRATIVE & GENERAL								6
7	MAINTENANCE & REPAIRS								7
8	OPERATION OF PLANT								8
9	LAUNDRY & LINEN SERVICE	239455							9
10	HOUSEKEEPING	34293	74542						10
11	DIETARY		6598	79890					11
12	CAFETERIA			50328	13346				12
13	MAINTENANCE OF PERSONNEL								13
14	NURSING ADMINISTRATION								14
15	CENTRAL SERVICES & SUPPLY					390125			15
16	PHARMACY						100		16
17	MEDICAL RECORDS & LIBRARY		2623		507			46317887	17
18	SOCIAL SERVICE								18
20	NONPHYSICIAN ANESTHETISTS								20
21	NURSING SCHOOL								21
22	I&R SERVICES-SALARY & FRINGES								22
23	I&R SERVICES-OTHER PRGM COSTS								23
24	PARAMED ED PRGM-(SPECIFY)								24
INPATIENT ROUTINE SERV COST CENTERS									
25	ADULTS & PEDIATRICS	50725	11107	8275	2202	6012		2646857	25
34	SKILLED NURSING FACILITY	83339	12342	21287	2211			1188018	34
ANCILLARY SERVICE COST CENTERS									
37	OPERATING ROOM	16963	4863		415	292964		3814867	37
38	RECOVERY ROOM				125				38
40	ANESTHESIOLOGY		231			11935			40
41	RADIOLOGY-DIAGNOSTIC	14272	4365		834			10882658	41
44	LABORATORY	239	1939		1013			7973661	44
46.30	BLOOD CLOTTING FACTORS ADMIN								46.30
49	RESPIRATORY THERAPY				57	22157		600821	49
50	PHYSICAL THERAPY	19770	3248		517	3617		2581079	50
51	OCCUPATIONAL THERAPY				93	414		419456	51
52	SPEECH PATHOLOGY		35					38875	52
53	ELECTROCARDIOLOGY	438	1739		199			399704	53
55	MEDICAL SUPPLIES CHARGED TO P		3528		36	18376		2907450	55
56	DRUGS CHARGED TO PATIENTS		1111		315		100	3275647	56
59.97	CARDIAC REHABILITATION								59.97
59.98	HYPERBARIC OXYGEN THERAPY								59.98
59.99	LITHOTRIPSY								59.99
OUTPATIENT SERVICE COST CENTERS									
61	EMERGENCY	16038	5094		777	4126		3745190	61
62	OBSERVATION BEDS (NON-DISTINC								62
63.50	RHC	2294	9206		3412	417		3750467	63.50
63.60	FQHC								63.60
OTHER REIMBURSABLE COST CENTERS									
69.10	CMHC								69.10
69.20	OUTPATIENT PHYSICAL THERAPY								69.20
69.30	OUTPATIENT OCCUPATIONAL THERA								69.30
69.40	OUTPATIENT SPEECH PATHOLOGY								69.40
71	HOME HEALTH AGENCY								71
SPECIAL PURPOSE COST CENTERS									
85.01	PANCREAS ACQUISITION								85.01
85.02	INTESTINAL ACQUISITION								85.02
85.03	ISLET CELL ACQUISITION								85.03
95	SUBTOTALS	238371	68029	79890	12713	360018	100	44224750	95
NONREIMBURSABLE COST CENTERS									
98	PHYSICIANS' PRIVATE OFFICES	1084	6513		633	30107		2093137	98
100	CLINIC								100
100.01	RENTAL SPACE								100.01

PROVIDER NO. 14-1318 OSF HOLY FAMILY MEDICAL CENTER
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KPMG LLP COMPU-MAX MICRO SYSTEM
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COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

COST CENTER DESCRIPTION	LAUNDRY + LINEN SERVICE POUNDS OF LAUNDRY 9	HOUSE- KEEPING SQUARE FEET 10	DIETARY MEALS SERVED 11	CAFETERIA FTE'S 12	CENTRAL SERVICES + SUPPLY COSTED REQUIS. 15	PHARMACY COSTED REQUIS. 16	MEDICAL RECORDS + LIBRARY GROSS REVENUE 17	
101 CROSS FOOT ADJUSTMENTS								101
102 NEGATIVE COST CENTER								102
103 COST TO BE ALLOC PER B PT I	140617	701676	1242000	782418			520564	103
104 UNIT COST MULT-WS B PT I	.587238		15.546376				.011239	104
104 UNIT COST MULT-WS B PT I		9.413163		58.625656				104
105 COST TO BE ALLOC PER B PT II								105
106 UNIT COST MULT-WS B PT II								106
106 UNIT COST MULT-WS B PT II								106
107 COST TO BE ALLOC PER B PT III	2167	23649	109325	68871			46034	107
108 UNIT COST MULT-WS B PT III	.009050		1.368444				.000994	108
108 UNIT COST MULT-WS B PT III		.317257		5.160423				108

PROVIDER NO. 14-1318 OSF HOLY FAMILY MEDICAL CENTER
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COMPUTATION OF RATIO OF COST TO CHARGES

WORKSHEET C
 PART I

COST CENTER DESCRIPTION	TOTAL COST (FROM WKST B, PART I, COL 27) 1	THERAPY LIMIT ADJUSTMENT 2	TOTAL COSTS 3	RCE DISALLOWANCE 4	TOTAL COSTS 5	
INPATIENT ROUTINE SERV COST CENTERS						
25 ADULTS & PEDIATRICS	2638393		2638393		2638393	25
34 SKILLED NURSING FACILITY	2700634		2700634		2700634	34
ANCILLARY SERVICE COST CENTERS						
37 OPERATING ROOM	1045199		1045199		1045199	37
38 RECOVERY ROOM	7328		7328		7328	38
40 ANESTHESIOLOGY	27056		27056		27056	40
41 RADIOLOGY-DIAGNOSTIC	2140003		2140003		2140003	41
44 LABORATORY	1743750		1743750		1743750	44
46.30 BLOOD CLOTTING FACTORS ADMI						46.30
49 RESPIRATORY THERAPY	87618		87618		87618	49
50 PHYSICAL THERAPY	782160	3917	786077		786077	50
51 OCCUPATIONAL THERAPY	134468		134468		134468	51
52 SPEECH PATHOLOGY	11486		11486		11486	52
53 ELECTROCARDIOLOGY	363629		363629		363629	53
55 MEDICAL SUPPLIES CHARGED TO	783148		783148		783148	55
56 DRUGS CHARGED TO PATIENTS	1202013		1202013		1202013	56
59.97 CARDIAC REHABILITATION						59.97
59.98 HYPERBARIC OXYGEN THERAPY						59.98
59.99 LITHOTRIPSY						59.99
OUTPATIENT SERVICE COST CENTERS						
61 EMERGENCY	1533473		1533473		1533473	61
62 OBSERVATION BEDS (NON-DISTI	313664		313664		313664	62
63.50 RHC	5285004		5285004		5285004	63.50
63.60 FQHC						63.60
OTHER REIMBURSABLE COST CENTERS						
101 SUBTOTAL	20799026	3917	20802943		20802943	101
102 LESS OBSERVATION BEDS	313664		313664		313664	102
103 TOTAL	20485362	3917	20489279		20489279	103

PROVIDER NO. 14-1318 OSF HOLY FAMILY MEDICAL CENTER
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COMPUTATION OF RATIO OF COST TO CHARGES

WORKSHEET C
 PART I (CONT)

COST CENTER DESCRIPTION		----- CHARGES -----			COST OR OTHER RATIO 9	TEFRA INPATIENT RATIO 10	PPS INPATIENT RATIO 11
		INPATIENT 6	OUTPATIENT 7	TOTAL 8			
25	INPATIENT ROUTINE SERV COST CENTERS						
34	ADULTS & PEDIATRICS	2418418		2418418			25
	SKILLED NURSING FACILITY	1188018		1188018			34
	ANCILLARY SERVICE COST CENTERS						
37	OPERATING ROOM	688080	3126787	3814867	.273980	.273980	.273980 37
38	RECOVERY ROOM						38
40	ANESTHESIOLOGY						40
41	RADIOLOGY-DIAGNOSTIC	1640478	9242180	10882658	.196643	.196643	.196643 41
44	LABORATORY	1466036	6507624	7973660	.218689	.218689	.218689 44
46.30	BLOOD CLOTTING FACTORS ADMI						46.30
49	RESPIRATORY THERAPY	348514	252307	600821	.145830	.145830	.145830 49
50	PHYSICAL THERAPY	365326	2215753	2581079	.303036	.304554	.304554 50
51	OCCUPATIONAL THERAPY	209030	210426	419456	.320577	.320577	.320577 51
52	SPEECH PATHOLOGY	33378	5497	38875	.295460	.295460	.295460 52
53	ELECTROCARDIOLOGY	4784	394920	399704	.909746	.909746	.909746 53
55	MEDICAL SUPPLIES CHARGED TO	802582	2104868	2907450	.269359	.269359	.269359 55
56	DRUGS CHARGED TO PATIENTS	2089540	1186107	3275647	.366954	.366954	.366954 56
59.97	CARDIAC REHABILITATION						59.97
59.98	HYPERBARIC OXYGEN THERAPY						59.98
59.99	LITHOTRIPSY						59.99
	OUTPATIENT SERVICE COST CENTERS						
61	EMERGENCY	1267951	2477239	3745190	.409451	.409451	.409451 61
62	OBSERVATION BEDS (NON-DISTI		369855	369855	.848073	.848073	.848073 62
63.50	RHC		3750467	3750467	1.409159	1.409159	1.409159 63.50
63.60	FQHC						63.60
	OTHER REIMBURSABLE COST CENTERS						
101	SUBTOTAL	12522135	31844030	44366165			101
102	LESS OBSERVATION BEDS						102
103	TOTAL	12522135	31844030	44366165			103

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APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

WORKSHEET D
 PARTS V & VI

CHECK [] TITLE V - O/P [XX] HOSPITAL (14-1318) [] SNF
 APPLICABLE [XX] TITLE XVIII-PT B [] SUB I [] NF
 BOXES [] TITLE XIX - O/P [] SUB II [] S/B-SNF
 [] SUB III [] S/B-NF
 [] SUB IV [] ICF/MR

COST CENTER DESCRIPTION	COST TO CHARGE RATIO FROM WORKSHEET C,			PROGRAM CHARGES		
	PART II COL. 8 1	PART I COL. 9 1.01	PART II COL. 9 1.02	OUTPATIENT AMBULATORY SURGICAL CENTER 2	OUTPATIENT RADIOLOGY 3	OTHER OUTPATIENT DIAGNOSTIC 4
ANCILLARY SERVICE COST CENTERS						
37 OPERATING ROOM	.273980	.273980	.273980			37
38 RECOVERY ROOM						38
40 ANESTHESIOLOGY						40
41 RADIOLOGY-DIAGNOSTIC	.196643	.196643	.196643			41
44 LABORATORY	.218689	.218689	.218689			44
46.30 BLOOD CLOTTING FACTORS ADMIN CO						46.30
49 RESPIRATORY THERAPY	.145830	.145830	.145830			49
50 PHYSICAL THERAPY	.303036	.303036	.303036			50
51 OCCUPATIONAL THERAPY	.320577	.320577	.320577			51
52 SPEECH PATHOLOGY	.295460	.295460	.295460			52
53 ELECTROCARDIOLOGY	.909746	.909746	.909746			53
55 MEDICAL SUPPLIES CHARGED TO PAT	.269359	.269359	.269359			55
56 DRUGS CHARGED TO PATIENTS	.366954	.366954	.366954			56
59.97 CARDIAC REHABILITATION						59.97
59.98 HYPERBARIC OXYGEN THERAPY						59.98
59.99 LITHOTRIPSY						59.99
OUTPATIENT SERVICE COST CENTERS						
61 EMERGENCY	.409451	.409451	.409451			61
62 OBSERVATION BEDS (NON-DISTINCT	.848073	.848073	.848073			62
63.50 RHC	1.409159	1.409159	1.409159			63.50
63.60 FQHC						63.60
OTHER REIMBURSABLE COST CENTERS						
65.01 AMBULANCE CHARGES (S-2 LINE 56.						65.01
65.02 AMBULANCE CHARGES (S-2 LINE 56.						65.02
65.03 AMBULANCE CHARGES (S-2 LINE 56.						65.03
101 SUBTOTAL						101
102 CRNA CHARGES						102
103 LESS PBP CLINIC LAB SERV-PGM ONLY CHRGS						103
104 NET CHARGES						104

PART VI - VACCINE COST APPORTIONMENT

1 DRUGS CHARGED TO PATIENTS - RATIO OF COST TO CHARGES	.366954	1
2 VACCINE CHARGES (OTHER THAN HEPATITIS B)		2
2.01 VACCINE CHARGES - HEPATITIS B		2.01
3 VACCINE COSTS (OTHER THAN HEPATITIS B)		3
3.01 VACCINE COSTS - HEPATITIS B		3.01

PROVIDER NO. 14-1318 OSF HOLY FAMILY MEDICAL CENTER
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KPMG LLP COMPU-MAX MICRO SYSTEM
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APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

WORKSHEET D
 PARTS V & VI

CHECK	[]	TITLE V - O/P	[XX]	HOSPITAL (14-1318)	[]	SNF
APPLICABLE	[XX]	TITLE XVIII-PT B	[]	SUB I	[]	NF
BOXES	[]	TITLE XIX - O/P	[]	SUB II	[]	S/B-SNF
			[]	SUB III	[]	S/B-NF
			[]	SUB IV	[]	ICF/MR

COST CENTER DESCRIPTION	PROGRAM CHARGES					PROGRAM COST		
	ALL	PPS SER-	ALL OTHER	PPS SER-	PPS SER-	OUTPATIENT		
	OTHER (1)	VICES	(SEE	VICES	VICES	AMBULATORY	OUTPATIENT	OUTPATIENT
	(SEE	(SEE	(SEE	(SEE	(SEE	SURGICAL	RADIOLOGY	DIAGNOSTIC
	INSTRU.)	INSTRU.)	INSTRU.)	INSTRU.)	INSTRU.)	CENTER		
	5	5.01	5.02	5.03	5.04	6	7	8
ANCILLARY SERVICE COST CENTERS								
37 OPERATING ROOM	794266							37
38 RECOVERY ROOM								38
40 ANESTHESIOLOGY								40
41 RADIOLOGY-DIAGNOSTIC	2990902							41
44 LABORATORY	2871412							44
46.30 BLOOD CLOTTING FACTORS ADMIN C								46.30
49 RESPIRATORY THERAPY	24676							49
50 PHYSICAL THERAPY	654128							50
51 OCCUPATIONAL THERAPY	68042							51
52 SPEECH PATHOLOGY	2651							52
53 ELECTROCARDIOLOGY	318731							53
55 MEDICAL SUPPLIES CHARGED TO PA	581825							55
56 DRUGS CHARGED TO PATIENTS	599481							56
59.97 CARDIAC REHABILITATION								59.97
59.98 HYPERBARIC OXYGEN THERAPY								59.98
59.99 LITHOTRIPSY								59.99
OUTPATIENT SERVICE COST CENTERS								
61 EMERGENCY	1124642							61
62 OBSERVATION BEDS (NON-DISTINCT	173804							62
63.50 RHC								63.50
63.60 FQHC								63.60
OTHER REIMBURSABLE COST CENTERS								
65.01 AMBULANCE CHARGES (S-2 LINE 56								65.01
65.02 AMBULANCE CHARGES (S-2 LINE 56								65.02
65.03 AMBULANCE CHARGES (S-2 LINE 56								65.03
101 SUBTOTAL	10204560							101
102 CRNA CHARGES								102
103 PBP CLINIC LAB								103
104 NET CHARGES	10204560							104

PROVIDER NO. 14-1318 OSF HOLY FAMILY MEDICAL CENTER
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KPMG LLP COMPU-MAX MICRO SYSTEM
 IN LIEU OF FORM CMS-2552-96 (8/2002)

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APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

WORKSHEET D
 PARTS V & VI

CHECK	[]	TITLE V - O/P	[XX]	HOSPITAL (14-1318)	[]	SNF
APPLICABLE	[XX]	TITLE XVIII-PT B	[]	SUB I	[]	NF
BOXES	[]	TITLE XIX - O/P	[]	SUB II	[]	S/B-SNF
			[]	SUB III	[]	S/B-NF
			[]	SUB IV	[]	ICF/MR

COST CENTER DESCRIPTION	PROGRAM COST					HOSPITAL	HOSPITAL
	ALL OTHER	PPS SERVICES	ALL OTHER	PPS SERVICES	PPS SERVICES	I/P PART B	I/P PART B
	(COLS 1x5)	(COLUMNS 1.01x5.01)	(COLUMNS 1.01x5.02)	(COLUMNS 1.01x5.03)	(COLUMNS 1.01x5.04)	CHARGES (SEE INSTRU.)	COST (COLUMNS 1.02x10)
	9	9.01	9.02	9.03	9.04	10	11
ANCILLARY SERVICE COST CENTERS							
37 OPERATING ROOM	217613						37
38 RECOVERY ROOM							38
40 ANESTHESIOLOGY							40
41 RADIOLOGY-DIAGNOSTIC	588140						41
44 LABORATORY	627946						44
46.30 BLOOD CLOTTING FACTORS ADMIN CO							46.30
49 RESPIRATORY THERAPY	3599						49
50 PHYSICAL THERAPY	198224						50
51 OCCUPATIONAL THERAPY	21813						51
52 SPEECH PATHOLOGY	783						52
53 ELECTROCARDIOLOGY	289964						53
55 MEDICAL SUPPLIES CHARGED TO PAT	156720						55
56 DRUGS CHARGED TO PATIENTS	219982						56
59.97 CARDIAC REHABILITATION							59.97
59.98 HYPERBARIC OXYGEN THERAPY							59.98
59.99 LITHOTRIPSY							59.99
OUTPATIENT SERVICE COST CENTERS							
61 EMERGENCY	460486						61
62 OBSERVATION BEDS (NON-DISTINCT	147398						62
63.50 RHC							63.50
63.60 FQHC							63.60
OTHER REIMBURSABLE COST CENTERS							
65.01 AMBULANCE CHARGES (S-2 LINE 56.							65.01
65.02 AMBULANCE CHARGES (S-2 LINE 56.							65.02
65.03 AMBULANCE CHARGES (S-2 LINE 56.							65.03
101 SUBTOTAL	2932668						101
102 CRNA CHARGES							102
103 LESS PBP CLINIC LAB SERV-PGM ONLY CHRGS							103
104 NET CHARGES	2932668						104

PROVIDER NO. 14-1318 OSF HOLY FAMILY MEDICAL CENTER
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APPORTIONMENT OF INPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D
 PART IV

CHECK	[]	TITLE V	[]	HOSPITAL	[]	SUB IV	[]	PPS
APPLICABLE	[XX]	TITLE XVIII-PT A	[]	SUB I	[XX]	SNF (14-5528)	[]	TEFRA
BOXES	[]	TITLE XIX	[]	SUB II	[]	NF		
			[]	SUB III	[]	ICF/MR		

COST CENTER DESCRIPTION	OUTPATIENT			N/A	N/A	N/A	TOTAL COSTS
	NONPHYSICIAN ANESTHETIST	NONPHYSICIAN ANESTHETIST	MEDICAL EDUCATION				
	COST 1	COST 1.01	COST 2				
ANCILLARY SERVICE COST CENTERS							
37 OPERATING ROOM							37
38 RECOVERY ROOM							38
40 ANESTHESIOLOGY							40
41 RADIOLOGY-DIAGNOSTIC							41
44 LABORATORY							44
46.30 BLOOD CLOTTING FACTORS ADMIN							46.30
49 RESPIRATORY THERAPY							49
50 PHYSICAL THERAPY							50
51 OCCUPATIONAL THERAPY							51
52 SPEECH PATHOLOGY							52
53 ELECTROCARDIOLOGY							53
55 MEDICAL SUPPLIES CHARGED TO P							55
56 DRUGS CHARGED TO PATIENTS							56
59.97 CARDIAC REHABILITATION							59.97
59.98 HYPERBARIC OXYGEN THERAPY							59.98
59.99 LITHOTRIPSY							59.99
OUTPATIENT SERVICE COST CENTERS							
61 EMERGENCY							61
62 OBSERVATION BEDS (NON-DISTINC							62
63.50 RHC							63.50
63.60 FQHC							63.60
OTHER REIMBURSABLE COST CENTERS							
101 TOTAL							101

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APPORTIONMENT OF INPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D
 PART IV

CHECK	[]	TITLE V	[]	HOSPITAL	[]	SUB IV	[]	PPS
APPLICABLE	[XX]	TITLE XVIII-PT A	[]	SUB I	[XX]	SNF (14-5528)	[]	TEFRA
BOXES	[]	TITLE XIX	[]	SUB II	[]	NF		
			[]	SUB III	[]	ICF/MR		

COST CENTER DESCRIPTION	OUTPATIENT PASS THROUGH COSTS 3.01	TOTAL CHARGES 4	RATIO OF COST TO CHARGES 5	OUTPATIENT RATIO OF COST TO CHARGES 5.01	INPATIENT PROGRAM CHARGES 6	INPATIENT PROGRAM PASS THROUGH COSTS 7	OUTPATIENT PROGRAM CHARGES 8
ANCILLARY SERVICE COST CENTERS							
37 OPERATING ROOM		3814867					37
38 RECOVERY ROOM							38
40 ANESTHESIOLOGY							40
41 RADIOLOGY-DIAGNOSTIC		10882658			3368		41
44 LABORATORY		7973660			6604		44
46.30 BLOOD CLOTTING FACTORS ADMIN							46.30
49 RESPIRATORY THERAPY		600821			15647		49
50 PHYSICAL THERAPY		2581079			32170		50
51 OCCUPATIONAL THERAPY		419456			16655		51
52 SPEECH PATHOLOGY		38875			1439		52
53 ELECTROCARDIOLOGY		399704					53
55 MEDICAL SUPPLIES CHARGED TO P		2907450			7061		55
56 DRUGS CHARGED TO PATIENTS		3275647			52477		56
59.97 CARDIAC REHABILITATION							59.97
59.98 HYPERBARIC OXYGEN THERAPY							59.98
59.99 LITHOTRIPSY							59.99
OUTPATIENT SERVICE COST CENTERS							
61 EMERGENCY		3745190					61
62 OBSERVATION BEDS (NON-DISTINC		369855					62
63.50 RHC		3750467					63.50
63.60 FQHC							63.60
OTHER REIMBURSABLE COST CENTERS							
101 TOTAL		37009262			135421		101

PROVIDER NO. 14-1318 OSF HOLY FAMILY MEDICAL CENTER
 PERIOD FROM 10/01/2008 TO 09/30/2009

KPMG LLP COMPU-MAX MICRO SYSTEM
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APPORTIONMENT OF INPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D
 PART IV

CHECK	[]	TITLE V	[]	HOSPITAL	[]	SUB IV	[]	PPS
APPLICABLE	[XX]	TITLE XVIII-PT A	[]	SUB I	[XX]	SNF (14-5528)	[]	TEFRA
BOXES	[]	TITLE XIX	[]	SUB II	[]	NF		
			[]	SUB III	[]	ICF/MR		

COST CENTER DESCRIPTION	OUTPATIENT PROGRAM CHARGES 8.01	OUTPATIENT PROGRAM CHARGES 8.02	OUTPATIENT PROGRAM PASS THROUGH COSTS 9	OUTPATIENT PROGRAM PASS THROUGH COSTS 9.01	OUTPATIENT PROGRAM PASS THROUGH COSTS 9.02	
ANCILLARY SERVICE COST CENTERS						
37 OPERATING ROOM						37
38 RECOVERY ROOM						38
40 ANESTHESIOLOGY						40
41 RADIOLOGY-DIAGNOSTIC						41
44 LABORATORY						44
46.30 BLOOD CLOTTING FACTORS ADMIN						46.30
49 RESPIRATORY THERAPY						49
50 PHYSICAL THERAPY						50
51 OCCUPATIONAL THERAPY						51
52 SPEECH PATHOLOGY						52
53 ELECTROCARDIOLOGY						53
55 MEDICAL SUPPLIES CHARGED TO P						55
56 DRUGS CHARGED TO PATIENTS						56
59.97 CARDIAC REHABILITATION						59.97
59.98 HYPERBARIC OXYGEN THERAPY						59.98
59.99 LITHOTRIPSY						59.99
OUTPATIENT SERVICE COST CENTERS						
61 EMERGENCY						61
62 OBSERVATION BEDS (NON-DISTINC						62
63.50 RHC						63.50
63.60 FQHC						63.60
OTHER REIMBURSABLE COST CENTERS						
101 TOTAL						101

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APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

WORKSHEET D
 PART I

CHECK [] TITLE V
 APPLICABLE [] TITLE XVIII-PT A
 BOXES [XX] TITLE XIX

COST CENTER DESCRIPTION		OLD CAPITAL		NEW CAPITAL		
		CAPITAL RELATED COST 1	SWING-BED ADJUSTMENT 2	CAPITAL RELATED COST 4	SWING-BED ADJUSTMENT 5	
25	INPAT ROUTINE SERV COST CTRS					25
26	ADULTS & PEDIATRICS			213365	75508	26
27	INTENSIVE CARE UNIT					27
28	CORONARY CARE UNIT					28
29	BURN INTENSIVE CARE UNIT					29
30	SURGICAL INTENSIVE CARE UNIT					30
31	OTHER SPECIAL CARE (SPECIFY)					31
33	SUBPROVIDER I					33
33	NURSERY					33
101	TOTAL			213365		101

COST CENTER DESCRIPTION		OLD CAPITAL		NEW CAPITAL		
		TOTAL PATIENT DAYS 7	INPATIENT PROGRAM DAYS 8	PER DIEM 9	INPATIENT PROGRAM CAPITAL COST 10	
25	INPAT ROUTINE SERV COST CTRS					25
26	ADULTS & PEDIATRICS	1875	76			26
27	INTENSIVE CARE UNIT				73.52	27
28	CORONARY CARE UNIT					28
29	BURN INTENSIVE CARE UNIT					29
30	SURGICAL INTENSIVE CARE UNIT					30
31	OTHER SPECIAL CARE (SPECIFY)					31
33	SUBPROVIDER I					33
33	NURSERY					33
101	TOTAL	1875	76			101

PROVIDER NO. 14-1318 OSF HOLY FAMILY MEDICAL CENTER
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APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

WORKSHEET D
 PART II

CHECK [] TITLE V [XX] HOSPITAL (14-1318) [] SUB III [XX] PPS
 APPLICABLE [] TITLE XVIII-PT A [] SUB I [] SUB IV [] TEFRA
 BOXES [XX] TITLE XIX [] SUB II [] OTHER

COST CENTER DESCRIPTION	OLD CAPITAL RELATED COST 1	NEW CAPITAL RELATED COST 2	TOTAL CHARGES 3	INPATIENT PROGRAM CHARGES 4	---- OLD CAPITAL ---- RATIO OF COST TO CHARGES 5	---- NEW CAPITAL ---- RATIO OF COST TO CHARGES 7	CAPITAL COSTS 6	CAPITAL COSTS 8
ANCILLARY SERVICE COST CENTERS								
37 OPERATING ROOM		87477	3814867			.022931		37
38 RECOVERY ROOM		645						38
40 ANESTHESIOLOGY		3574						40
41 RADIOLOGY-DIAGNOSTIC		105121	10882658			.009659		41
44 LABORATORY		64238	7973660			.008056		44
46.30 BLOOD CLOTTING FACTORS ADMIN								46.30
49 RESPIRATORY THERAPY		2086	600821			.003472		49
50 PHYSICAL THERAPY		60769	2581079			.023544		50
51 OCCUPATIONAL THERAPY		2813	419456			.006706		51
52 SPEECH PATHOLOGY		688	38875			.017698		52
53 ELECTROCARDIOLOGY		30548	399704			.076427		53
55 MEDICAL SUPPLIES CHARGED TO P		62831	2907450			.021610		55
56 DRUGS CHARGED TO PATIENTS		37742	3275647			.011522		56
59.97 CARDIAC REHABILITATION								59.97
59.98 HYPERBARIC OXYGEN THERAPY								59.98
59.99 LITHOTRIPSY								59.99
OUTPATIENT SERVICE COST CENTERS								
61 EMERGENCY		99642	3745190			.026605		61
62 OBSERVATION BEDS (NON-DISTINC			369855					62
63.50 RHC			3750467					63.50
63.60 FQHC								63.60
OTHER REIMBURSABLE COST CENTERS								
101 TOTAL		558174	37009262					101

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APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D
 PART III

CHECK [] TITLE V
 APPLICABLE [] TITLE XVIII-PT A
 BOXES [XX] TITLE XIX

	COST CENTER DESCRIPTION	NONPHYSICIAN ANESTHETIST COST 1	MEDICAL EDUCATION COST 2	SWING-BED ADJUSTMENT AMOUNT 3	TOTAL COSTS 4	TOTAL PATIENT DAYS 5	PER DIEM 6	INPATIENT PROGRAM DAYS 7	INPATIENT PROGRAM PASS THRU COSTS 8
	INPAT ROUTINE SERV COST CTRS								
25	ADULTS & PEDIATRICS					1875		76	25
26	INTENSIVE CARE UNIT								26
27	CORONARY CARE UNIT								27
28	BURN INTENSIVE CARE UNIT								28
29	SURGICAL INTENSIVE CARE UNIT								29
30	OTHER SPECIAL CARE (SPECIFY)								30
31	SUBPROVIDER I								31
33	NURSERY								33
34	SKILLED NURSING FACILITY					7233			34
35	NURSING FACILITY								35
101	TOTAL					9108		76	101

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APPORTIONMENT OF INPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D
 PART IV

CHECK	[]	TITLE V	[XX]	HOSPITAL (14-1318)	[]	SUB IV	[]	PPS
APPLICABLE	[]	TITLE XVIII-PT A	[]	SUB I	[]	SNF	[]	TEFRA
BOXES	[XX]	TITLE XIX	[]	SUB II	[]	NF	[]	OTHER
			[]	SUB III	[]	ICF/MR		

COST CENTER DESCRIPTION	OUTPATIENT			N/A	N/A	N/A	TOTAL COSTS
	NONPHYSICIAN ANESTHETIST	NONPHYSICIAN ANESTHETIST	MEDICAL EDUCATION				
	COST	COST	COST				
	1	1.01	2	2.01	2.02	2.03	3
ANCILLARY SERVICE COST CENTERS							
37 OPERATING ROOM							37
38 RECOVERY ROOM							38
40 ANESTHESIOLOGY							40
41 RADIOLOGY-DIAGNOSTIC							41
44 LABORATORY							44
46.30 BLOOD CLOTTING FACTORS ADMIN							46.30
49 RESPIRATORY THERAPY							49
50 PHYSICAL THERAPY							50
51 OCCUPATIONAL THERAPY							51
52 SPEECH PATHOLOGY							52
53 ELECTROCARDIOLOGY							53
55 MEDICAL SUPPLIES CHARGED TO P							55
56 DRUGS CHARGED TO PATIENTS							56
59.97 CARDIAC REHABILITATION							59.97
59.98 HYPERBARIC OXYGEN THERAPY							59.98
59.99 LITHOTRIPSY							59.99
OUTPATIENT SERVICE COST CENTERS							
61 EMERGENCY							61
62 OBSERVATION BEDS (NON-DISTINC							62
63.50 RHC							63.50
63.60 FQHC							63.60
OTHER REIMBURSABLE COST CENTERS							
101 TOTAL							101

PROVIDER NO. 14-1318 OSF HOLY FAMILY MEDICAL CENTER
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APPORTIONMENT OF INPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D
 PART IV

CHECK	[]	TITLE V	[XX]	HOSPITAL (14-1318)	[]	SUB IV	[]	PPS
APPLICABLE	[]	TITLE XVIII-PT A	[]	SUB I	[]	SNF	[]	TEFRA
BOXES	[XX]	TITLE XIX	[]	SUB II	[]	NF	[]	OTHER
			[]	SUB III	[]	ICF/MR		

COST CENTER DESCRIPTION	OUTPATIENT PASS THROUGH COSTS 3.01	TOTAL CHARGES 4	RATIO OF COST TO CHARGES 5	OUTPATIENT RATIO OF COST TO CHARGES 5.01	INPATIENT PROGRAM CHARGES 6	INPATIENT PROGRAM PASS THROUGH COSTS 7	OUTPATIENT PROGRAM CHARGES 8
ANCILLARY SERVICE COST CENTERS							
37 OPERATING ROOM		3814867					37
38 RECOVERY ROOM							38
40 ANESTHESIOLOGY							40
41 RADIOLOGY-DIAGNOSTIC		10882658					41
44 LABORATORY		7973660					44
46.30 BLOOD CLOTTING FACTORS ADMIN							46.30
49 RESPIRATORY THERAPY		600821					49
50 PHYSICAL THERAPY		2581079					50
51 OCCUPATIONAL THERAPY		419456					51
52 SPEECH PATHOLOGY		38875					52
53 ELECTROCARDIOLOGY		399704					53
55 MEDICAL SUPPLIES CHARGED TO P		2907450					55
56 DRUGS CHARGED TO PATIENTS		3275647					56
59.97 CARDIAC REHABILITATION							59.97
59.98 HYPERBARIC OXYGEN THERAPY							59.98
59.99 LITHOTRIPSY							59.99
OUTPATIENT SERVICE COST CENTERS							
61 EMERGENCY		3745190					61
62 OBSERVATION BEDS (NON-DISTINC		369855					62
63.50 RHC		3750467					63.50
63.60 FQHC							63.60
OTHER REIMBURSABLE COST CENTERS							
101 TOTAL		37009262					101

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APPORTIONMENT OF INPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D
 PART IV

CHECK	[]	TITLE V	[XX]	HOSPITAL (14-1318)	[]	SUB IV	[]	PPS
APPLICABLE	[]	TITLE XVII11-PT A	[]	SUB I	[]	SNF	[]	TEFRA
BOXES	[XX]	TITLE XIX	[]	SUB II	[]	NF	[]	OTHER
			[]	SUB III	[]	ICF/MR		

COST CENTER DESCRIPTION	OUTPATIENT PROGRAM CHARGES 8.01	OUTPATIENT PROGRAM CHARGES 8.02	OUTPATIENT PROGRAM PASS THROUGH COSTS 9	OUTPATIENT PROGRAM PASS THROUGH COSTS 9.01	OUTPATIENT PROGRAM PASS THROUGH COSTS 9.02	
ANCILLARY SERVICE COST CENTERS						
37 OPERATING ROOM						37
38 RECOVERY ROOM						38
40 ANESTHESIOLOGY						40
41 RADIOLOGY-DIAGNOSTIC						41
44 LABORATORY						44
46.30 BLOOD CLOTTING FACTORS ADMIN						46.30
49 RESPIRATORY THERAPY						49
50 PHYSICAL THERAPY						50
51 OCCUPATIONAL THERAPY						51
52 SPEECH PATHOLOGY						52
53 ELECTROCARDIOLOGY						53
55 MEDICAL SUPPLIES CHARGED TO P						55
56 DRUGS CHARGED TO PATIENTS						56
59.97 CARDIAC REHABILITATION						59.97
59.98 HYPERBARIC OXYGEN THERAPY						59.98
59.99 LITHOTRIPSY						59.99
OUTPATIENT SERVICE COST CENTERS						
61 EMERGENCY						61
62 OBSERVATION BEDS (NON-DISTINC						62
63.50 RHC						63.50
63.60 FQHC						63.60
OTHER REIMBURSABLE COST CENTERS						
101 TOTAL						101

PROVIDER NO. 14-1318 OSF HOLY FAMILY MEDICAL CENTER
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COMPUTATION OF INPATIENT OPERATING COST

WORKSHEET D-1
 PART I

[] TITLE V-INPT

[XX] TITLE XVIII-PART A

[] TITLE XIX-INPT

PART I - ALL PROVIDER COMPONENTS

	HOSPITAL (OTHER) (14-1318)	SUB I 1	SUB II 1	SUB III 1	SUB IV 1	SNF (PPS) (14-5528)	
INPATIENT DAYS	1	1	1	1	1	1	
1 INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS AND SWING-BED DAYS EXCLUDING NEWBORN)	2902					7233	1
2 INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS, EXCLUDING SWING BED AND NEWBORN DAYS)	1875					7233	2
3 PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)							3
4 SEMI-PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)	1875					7233	4
5 TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	1027						5
6 TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD							6
7 TOTAL SWING-BED NF-TYPE INPATIENT DAYS (INCL PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD							7
8 TOTAL SWING-BED NF-TYPE INPATIENT DAYS (INCL PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD							8
9 INPATIENT DAYS INCLUDING PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (EXCLUDING SWING-BED AND NEWBORN DAYS)	1110					283	9
10 SWING-BED SNF-TYPE INPATIENT DAYS APPLICABLE TO TITLE XVIII ONLY (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	958						10
11 SWING-BED SNF-TYPE INPATIENT DAYS APPLICABLE TO TITLE XVIII ONLY (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD							11
12 SWING-BED NF-TYPE INPATIENT DAYS APPLICABLE TO TITLES V OR XIX ONLY (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD							12
13 SWING-BED NF-TYPE INPATIENT DAYS APPLICABLE TO TITLES V OR XIX ONLY (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD							13
14 MEDICALLY NECESSARY PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (EXCLUDING SWING-BED DAYS)							14
15 TOTAL NURSERY DAYS							15
16 TITLE V OR XIX NURSERY DAYS							16

PROVIDER NO. 14-1318 OSF HOLY FAMILY MEDICAL CENTER
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COMPUTATION OF INPATIENT OPERATING COST

WORKSHEET D-1
 PART I (CONT)

[] TITLE V-INPT

[XX] TITLE XVIII-PART A

[] TITLE XIX-INPT

PART I - ALL PROVIDER COMPONENTS

	HOSPITAL (OTHER) (14-1318)	SUB I	SUB II	SUB III	SUB IV	SNF (PPS) (14-5528)	
SWING-BED ADJUSTMENT	1	1	1	1	1	1	
17 MEDICARE RATE FOR SWING-BED SNF SERVICES APPLICABLE TO SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD							17
18 MEDICARE RATE FOR SWING-BED SNF SERVICES APPLICABLE TO SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD							18
19 MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	100.00						19
20 MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD	100.00						20
21 TOTAL GENERAL INPATIENT ROUTINE SERVICE COST	2638393					2700634	21
22 SWING-BED COST APPLICABLE TO SNF-TYPE SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD							22
23 SWING-BED COST APPLICABLE TO SNF-TYPE SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD							23
24 SWING-BED COST APPLICABLE TO NF-TYPE SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD							24
25 SWING-BED COST APPLICABLE TO NF-TYPE SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD							25
26 TOTAL SWING-BED COST	933707						26
27 GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST	1704686					2700634	27
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT							
28 GENERAL INPATIENT ROUTINE SERVICE CHARGES (EXCLUDING SWING-BED CHARGES)	1719643					1188018	28
29 PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)							29
30 SEMI-PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)	1719643					1188018	30
31 GENERAL INPATIENT ROUTINE SERVICE COST/CHARGE RATIO	.991302					2.273226	31
32 AVERAGE PRIVATE ROOM PER DIEM CHARGE							32
33 AVERAGE SEMI-PRIVATE ROOM PER DIEM CHARGE	917.14					164.25	33
34 AVERAGE PER DIEM PRIVATE ROOM CHARGE DIFFERENTIAL							34
35 AVERAGE PER DIEM PRIVATE ROOM COST DIFFERENTIAL							35
36 PRIVATE ROOM COST DIFFERENTIAL ADJUSTMENT							36
37 GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST AND PRIVATE ROOM COST DIFFERENTIAL	1704686					2700634	37

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COMPUTATION OF INPATIENT OPERATING COST

WORKSHEET D-1
 PART II

[] TITLE V-INPT

[XX] TITLE XVIII-PART A

[] TITLE XIX-INPT

PART II - HOSPITAL AND SUBPROVIDERS ONLY

	HOSPITAL (OTHER) (14-1318)	SUB I	SUB II	SUB III	SUB IV	
PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS	1	1	1	1	1	
38 ADJUSTED GENERAL INPATIENT ROUTINE SERVICE COST PER DIEM	909.16					38
39 PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST	1009168					39
40 MEDICALLY NECESSARY PRIVATE ROOM COST APPLICABLE TO THE PROGRAM						40
41 TOTAL PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST	1009168					41
	TOTAL I/P COST	TOTAL I/P DAYS	AVERAGE PER DIEM	PROGRAM DAYS	PROGRAM COST	
	1	2	3	4	5	
42 NURSERY (TITLES V AND XIX ONLY)						42
INTENSIVE CARE TYPE INPATIENT HOSPITAL UNITS						
43 INTENSIVE CARE UNIT						43
44 CORONARY CARE UNIT						44
45 BURN INTENSIVE CARE UNIT						45
46 SURGICAL INTENSIVE CARE UNIT						46
47 OTHER SPECIAL CARE (SPECIFY)						47
	HOSPITAL (OTHER) (14-1318)	SUB I	SUB II	SUB III	SUB IV	
	1	1	1	1	1	
48 PROGRAM INPATIENT ANCILLARY SERVICE COST	831609					48
49 TOTAL PROGRAM INPATIENT COSTS	1840777					49
PASS THROUGH COST ADJUSTMENTS						
50 PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ROUTINE SERVICES						50
51 PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ANCILLARY SERVICES						51
52 TOTAL PROGRAM EXCLUDABLE COST						52
53 TOTAL PROGRAM INPATIENT OPERATING COST EXCLUDING CAPITAL RELATED, NONPHYSICIAN ANESTHETIST AND MEDICAL EDUCATION COSTS						53

PROVIDER NO. 14-1318 OSF HOLY FAMILY MEDICAL CENTER
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COMPUTATION OF INPATIENT OPERATING COST

WORKSHEET D-1
PART II (CONT)

[] TITLE V-INPT

[XX] TITLE XVIII-PART A

[] TITLE XIX-INPT

PART II - HOSPITAL AND SUBPROVIDERS ONLY

	HOSPITAL (OTHER) (14-1318)	SUB I	SUB II	SUB III	SUB IV	
TARGET AMOUNT AND LIMITATION COMPUTATION	1	1	1	1	1	
54 PROGRAM DISCHARGES						54
55 TARGET AMOUNT PER DISCHARGE						55
56 TARGET AMOUNT						56
57 DIFFERENCE BETWEEN ADJUSTED INPATIENT OPERATING COST AND TARGET AMOUNT						57
58 BONUS PAYMENT						58
58.01 LESSER OF LINE 53/LINE 54 OR LINE 55 FROM THE COST REPORTING PERIOD ENDING 1996, UPDATED & COMPOUNDED BY THE MARKET BASKET						58.01
58.02 LESSER OF LINE 53/LINE 54 OR LINE 55 FROM PRIOR YEAR COST REPORT UPDATED BY THE MARKET BASKET						58.02
58.03 IF LINE 53/LINE 54 IS LESS THAN THE LOWER OF LINES 55, 58.01 OR 58.02, THE LESSER OF 50% OF THE AMOUNT BY WHICH OPERATING COSTS ARE LESS THAN EXPECTED COSTS, OR 1% OF THE TARGET AMOUNT						58.03
58.04 RELIEF PAYMENT						58.04
59 ALLOWABLE INPATIENT COST PLUS INCENTIVE PAYMENT						59
59.01 ALLOWABLE INPATIENT COST PER DISCHARGE (LTCH ONLY)						59.01
59.02 PROGRAM DISCHARGES PRIOR TO JULY 1						59.02
59.03 PROGRAM DISCHARGES AFTER JULY 1						59.03
59.04 PROGRAM DISCHARGES (SEE INSTRUCTIONS)						59.04
59.05 REDUCED INPAT COST PER DISCH. FOR DISCHARGES PRIOR TO JULY 1						59.05
59.06 REDUCED INPAT COST PER DISCHARGE FOR DISCHARGES AFTER JULY 1						59.06
59.07 REDUCED INPAT COST PER DISCHARGE (SEE INSTR.) (LTCH ONLY)						59.07
59.08 REDUCED INPATIENT COST PLUS INCENTIVE PAYMENT (SEE INSTR.)						59.08
PROGRAM INPATIENT ROUTINE SWING BED COST						
60 MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	870975					60
61 MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS AFTER DECEMBER 31 OF THE COST REPORTING PERIOD						61
62 TOTAL MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS	870975					62
63 TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD						63
64 TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS AFTER DECEMBER 31 OF THE COST REPORTING PERIOD						64
65 TOTAL TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS						65

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COMPUTATION OF INPATIENT OPERATING COST

WORKSHEET D-1
PARTS III & IV

[] TITLE V-INPT

[XX] TITLE XVIII-PART A

[] TITLE XIX-INPT

PART III - SKILLED NURSING FACILITY, NURSING FACILITY AND ICF/MR ONLY

	SNF	
	(PPS)	
	(14-5528)	
	1	
66 SNF/NF/ICF/MR ROUTINE SERVICE COST	2700634	66
67 ADJUSTED GENERAL INPATIENT ROUTINE SERVICE COST PER DIEM	373.38	67
68 PROGRAM ROUTINE SERVICE COST	105667	68
69 MEDICALLY NECESSARY PRIVATE ROOM COST APPLICABLE TO PROGRAM		69
70 TOTAL PROGRAM GENERAL INPATIENT ROUTINE SERVICE COSTS	105667	70
71 CAPITAL RELATED COST ALLOCATED TO INPATIENT ROUTINE SERV COSTS	288839	71
72 PER DIEM CAPITAL RELATED COSTS	39.93	72
73 PROGRAM CAPITAL RELATED COSTS	11300	73
74 INPATIENT ROUTINE SERVICE COST	94367	74
75 AGGREGATE CHARGES TO BENEFICIARIES FOR EXCESS COSTS		75
76 TOTAL PGM ROUTINE SERVICE COSTS FOR COMPARISON TO COST LIMIT	94367	76
77 INPATIENT ROUTINE SERVICE COST PER DIEM LIMITATION		77
78 INPATIENT ROUTINE SERVICE COST LIMITATION		78
79 REASONABLE INPATIENT ROUTINE SERVICE COSTS	105667	79
80 PROGRAM INPATIENT ANCILLARY SERVICES	41060	80
81 UTILIZATION REVIEW--PHYSICIAN COMPENSATION		81
82 TOTAL PROGRAM INPATIENT OPERATING COSTS	146727	82

COMPUTATION OF INPATIENT OPERATING COST

WORKSHEET D-1
PARTS III & IV

[] TITLE V-INPT		[XX] TITLE XVIII-PART A		[] TITLE XIX-INPT	
		HOSPITAL	SUB I	SUB II	SUB III
		(OTHER)			SUB IV
		(14-1318)			
		1	1	1	1
PART IV - COMPUTATION OF OBSERVATION BED COST					
83 TOTAL OBSERVATION BEDS		345		83	
84 ADJUSTED GENERAL INPATIENT ROUTINE COST PER DIEM		909.17		84	
85 OBSERVATION BED COST		313664		85	

PROVIDER NO. 14-131* OSF HOLY FAMILY MEDICAL CENTER
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COMPUTATION OF INPATIENT OPERATING COST

WORKSHEET D-1
PART I

[] TITLE V-INPT

[] TITLE XVIII-PART A

[XX] TITLE XIX-INPT

PART I - ALL PROVIDER COMPONENTS

	HOSPITAL (PPS) (14-1318)	SUB I	SUB II	SUB III	SUB IV	NF
INPATIENT DAYS	1	1	1	1	1	1
1 INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS AND SWING-BED DAYS EXCLUDING NEWBORN)	2902					1
2 INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS, EXCLUDING SWING BED AND NEWBORN DAYS)	1875					2
3 PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)						3
4 SEMI-PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)	1875					4
5 TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	1027					5
6 TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD						6
7 TOTAL SWING-BED NF-TYPE INPATIENT DAYS (INCL PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD						7
8 TOTAL SWING-BED NF-TYPE INPATIENT DAYS (INCL PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD						8
9 INPATIENT DAYS INCLUDING PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (EXCLUDING SWING-BED AND NEWBORN DAYS)	76					9
10 SWING-BED SNF-TYPE INPATIENT DAYS APPLICABLE TO TITLE XVIII ONLY (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD						10
11 SWING-BED SNF-TYPE INPATIENT DAYS APPLICABLE TO TITLE XVIII ONLY (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD						11
12 SWING-BED NF-TYPE INPATIENT DAYS APPLICABLE TO TITLES V OR XIX ONLY (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD						12
13 SWING-BED NF-TYPE INPATIENT DAYS APPLICABLE TO TITLES V OR XIX ONLY (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD						13
14 MEDICALLY NECESSARY PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (EXCLUDING SWING-BED DAYS)						14
15 TOTAL NURSERY DAYS						15
16 TITLE V OR XIX NURSERY DAYS						16

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COMPUTATION OF INPATIENT OPERATING COST

WORKSHEET D-1
 PART I (CONT)

[] TITLE V-INPT

[] TITLE XVIII-PART A

[XX] TITLE XIX-INPT

PART I - ALL PROVIDER COMPONENTS

	HOSPITAL (PPS) (14-1318)	SUB I	SUB II	SUB III	SUB IV	NF	
SWING-BED ADJUSTMENT	1	1	1	1	1	1	
17 MEDICARE RATE FOR SWING-BED SNF SERVICES APPLICABLE TO SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD							17
18 MEDICARE RATE FOR SWING-BED SNF SERVICES APPLICABLE TO SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD							18
19 MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	100.00						19
20 MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD	100.00						20
21 TOTAL GENERAL INPATIENT ROUTINE SERVICE COST	2638393						21
22 SWING-BED COST APPLICABLE TO SNF-TYPE SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD							22
23 SWING-BED COST APPLICABLE TO SNF-TYPE SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD							23
24 SWING-BED COST APPLICABLE TO NF-TYPE SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD							24
25 SWING-BED COST APPLICABLE TO NF-TYPE SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD							25
26 TOTAL SWING-BED COST	933707						26
27 GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST	1704686						27
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT							
28 GENERAL INPATIENT ROUTINE SERVICE CHARGES (EXCLUDING SWING-BED CHARGES)	1719643						28
29 PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)							29
30 SEMI-PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)	1719643						30
31 GENERAL INPATIENT ROUTINE SERVICE COST/CHARGE RATIO	.991302						31
32 AVERAGE PRIVATE ROOM PER DIEM CHARGE							32
33 AVERAGE SEMI-PRIVATE ROOM PER DIEM CHARGE	917.14						33
34 AVERAGE PER DIEM PRIVATE ROOM CHARGE DIFFERENTIAL							34
35 AVERAGE PER DIEM PRIVATE ROOM COST DIFFERENTIAL							35
36 PRIVATE ROOM COST DIFFERENTIAL ADJUSTMENT							36
37 GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST AND PRIVATE ROOM COST DIFFERENTIAL	1704686						37

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COMPUTATION OF INPATIENT OPERATING COST

WORKSHEET D-1
PART II

[] TITLE V-INPT

[] TITLE XVIII-PART A

[XX] TITLE XIX-INPT

PART II - HOSPITAL AND SUBPROVIDERS ONLY

	HOSPITAL (PPS) (14-1318)	SUB I	SUB II	SUB III	SUB IV	
PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS	1	1	1	1	1	
38 ADJUSTED GENERAL INPATIENT ROUTINE SERVICE COST PER DIEM	909.16					38
39 PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST	69096					39
40 MEDICALLY NECESSARY PRIVATE ROOM COST APPLICABLE TO THE PROGRAM						40
41 TOTAL PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST	69096					41
	TOTAL I/P COST 1	TOTAL I/P DAYS 2	AVERAGE PER DIEM 3	PROGRAM DAYS 4	PROGRAM COST 5	
42 NURSERY (TITLES V AND XIX ONLY)						42
INTENSIVE CARE TYPE INPATIENT HOSPITAL UNITS						
43 INTENSIVE CARE UNIT						43
44 CORONARY CARE UNIT						44
45 BURN INTENSIVE CARE UNIT						45
46 SURGICAL INTENSIVE CARE UNIT						46
47 OTHER SPECIAL CARE (SPECIFY)						47
	HOSPITAL (PPS) (14-1318)	SUB I	SUB II	SUB III	SUB IV	
	1	1	1	1	1	
48 PROGRAM INPATIENT ANCILLARY SERVICE COST						48
49 TOTAL PROGRAM INPATIENT COSTS	69096					49
PASS THROUGH COST ADJUSTMENTS						
50 PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ROUTINE SERVICES	5588					50
51 PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ANCILLARY SERVICES						51
52 TOTAL PROGRAM EXCLUDABLE COST	5588					52
53 TOTAL PROGRAM INPATIENT OPERATING COST EXCLUDING CAPITAL RELATED, NONPHYSICIAN ANESTHETIST AND MEDICAL EDUCATION COSTS	63508					53

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WORKSHEET D-1
PART II (CONT)

[] TITLE V-INPT

[] TITLE XVIII-PART A

[XX] TITLE XIX-INPT

PART II - HOSPITAL AND SUBPROVIDERS ONLY

	HOSPITAL (PPS) (14-1318)	SUB I	SUB II	SUB III	SUB IV	
TARGET AMOUNT AND LIMITATION COMPUTATION	1	1	1	1	1	
54 PROGRAM DISCHARGES						54
55 TARGET AMOUNT PER DISCHARGE						55
56 TARGET AMOUNT						56
57 DIFFERENCE BETWEEN ADJUSTED INPATIENT OPERATING COST AND TARGET AMOUNT						57
58 BONUS PAYMENT						58
58.01 LESSER OF LINE 53/LINE 54 OR LINE 55 FROM THE COST REPORTING PERIOD ENDING 1996, UPDATED & COMPOUNDED BY THE MARKET BASKET						58.01
58.02 LESSER OF LINE 53/LINE 54 OR LINE 55 FROM PRIOR YEAR COST REPORT UPDATED BY THE MARKET BASKET						58.02
58.03 IF LINE 53/LINE 54 IS LESS THAN THE LOWER OF LINES 55, 58.01 OR 58.02, THE LESSER OF 50% OF THE AMOUNT BY WHICH OPERATING COSTS ARE LESS THAN EXPECTED COSTS, OR 1% OF THE TARGET AMOUNT						58.03
58.04 RELIEF PAYMENT						58.04
59 ALLOWABLE INPATIENT COST PLUS INCENTIVE PAYMENT						59
59.01 ALLOWABLE INPATIENT COST PER DISCHARGE (LTCH ONLY)						59.01
59.02 PROGRAM DISCHARGES PRIOR TO JULY 1						59.02
59.03 PROGRAM DISCHARGES AFTER JULY 1						59.03
59.04 PROGRAM DISCHARGES (SEE INSTRUCTIONS)						59.04
59.05 REDUCED INPAT COST PER DISCH. FOR DISCHARGES PRIOR TO JULY 1						59.05
59.06 REDUCED INPAT COST PER DISCHARGE FOR DISCHARGES AFTER JULY 1						59.06
59.07 REDUCED INPAT COST PER DISCHARGE (SEE INSTR.) (LTCH ONLY)						59.07
59.08 REDUCED INPATIENT COST PLUS INCENTIVE PAYMENT (SEE INSTR.)						59.08
PROGRAM INPATIENT ROUTINE SWING BED COST						
60 MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD						60
61 MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS AFTER DECEMBER 31 OF THE COST REPORTING PERIOD						61
62 TOTAL MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS						62
63 TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD						63
64 TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS AFTER DECEMBER 31 OF THE COST REPORTING PERIOD						64
65 TOTAL TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS						65

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WORKSHEET D-1
PARTS III & IV

[] TITLE V-INPT

[] TITLE XVIII-PART A

[XX] TITLE XIX-INPT

PART III - SKILLED NURSING FACILITY, NURSING FACILITY AND ICF/MR ONLY

NF

1

66 SNF/NF/ICF/MR ROUTINE SERVICE COST
67 ADJUSTED GENERAL INPATIENT ROUTINE SERVICE COST PER DIEM
68 PROGRAM ROUTINE SERVICE COST
69 MEDICALLY NECESSARY PRIVATE ROOM COST APPLICABLE TO PROGRAM
70 TOTAL PROGRAM GENERAL INPATIENT ROUTINE SERVICE COSTS
71 CAPITAL RELATED COST ALLOCATED TO INPATIENT ROUTINE SERV COSTS
72 PER DIEM CAPITAL RELATED COSTS
73 PROGRAM CAPITAL RELATED COSTS
74 INPATIENT ROUTINE SERVICE COST
75 AGGREGATE CHARGES TO BENEFICIARIES FOR EXCESS COSTS
76 TOTAL PGM ROUTINE SERVICE COSTS FOR COMPARISON TO COST LIMIT
77 INPATIENT ROUTINE SERVICE COST PER DIEM LIMITATION
78 INPATIENT ROUTINE SERVICE COST LIMITATION
79 REASONABLE INPATIENT ROUTINE SERVICE COSTS
80 PROGRAM INPATIENT ANCILLARY SERVICES
81 UTILIZATION REVIEW--PHYSICIAN COMPENSATION
82 TOTAL PROGRAM INPATIENT OPERATING COSTS

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COMPUTATION OF INPATIENT OPERATING COST

WORKSHEET D-1
PARTS III & IV

[] TITLE V-INPT

[] TITLE XVIII-PART A

[XX] TITLE XIX-INPT

HOSPITAL (PPS) (14-1318)	SUB I	SUB II	SUB III	SUB IV
1	1	1	1	1

PART IV - COMPUTATION OF OBSERVATION BED COST

83 TOTAL OBSERVATION BEDS	345	83
84 ADJUSTED GENERAL INPATIENT ROUTINE COST PER DIEM	909.17	84
85 OBSERVATION BED COST	313664	85

COMPUTATION OF OBSERVATION BED PASS THROUGH COST - HOSPITAL

	COST 1	ROUTINE COST (FROM LINE 27) 2	COLUMN 1 DIVIDED BY COLUMN 2 3	TOTAL OBSERVATION BED COST (FROM LINE 85) 4	OBSERVATION BED PASS-THROUGH COST COL 3 TIMES COL 4 5
86 OLD CAPITAL-RELATED COST		1704686		313664	86
87 NEW CAPITAL-RELATED COST		1704686		313664	87
88 NON PHYSICIAN ANESTHETIST		1704686		313664	88
89 MEDICAL EDUCATION		1704686		313664	89

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INPATIENT ANCILLARY COST APPORTIONMENT

WORKSHEET D-4

<input type="checkbox"/> TITLE V	<input checked="" type="checkbox"/> HOSPITAL (14-1318)	<input type="checkbox"/> SNF	<input type="checkbox"/> PPS
<input checked="" type="checkbox"/> TITLE XVIII-PT A	<input type="checkbox"/> SUB I	<input type="checkbox"/> NF	<input type="checkbox"/> TEFRA
<input type="checkbox"/> TITLE XIX	<input type="checkbox"/> SUB II	<input type="checkbox"/> S/B-SNF	<input checked="" type="checkbox"/> OTHER
	<input type="checkbox"/> SUB III	<input type="checkbox"/> S/B-NF	
	<input type="checkbox"/> SUB IV	<input type="checkbox"/> ICF/MR	

COST CENTER DESCRIPTION	RATIO OF COST TO CHARGES 1	INPATIENT PROGRAM CHARGES 2	INPATIENT PROGRAM COSTS 3	
INPATIENT ROUTINE SERVICE COST CENTERS				
25 ADULTS & PEDIATRICS		1229427		25
ANCILLARY SERVICE COST CENTERS				
37 OPERATING ROOM	.273480	345776	94736	37
38 RECOVERY ROOM				38
40 ANESTHESIOLOGY				40
41 RADIOLOGY-DIAGNOSTIC	.196643	545694	107307	41
44 LABORATORY	.218689	557215	121857	44
46.30 BLOOD CLOTTING FACTORS ADMIN CO				46.30
49 RESPIRATORY THERAPY	.145830	190177	27734	49
50 PHYSICAL THERAPY	.303036	51284	15541	50
51 OCCUPATIONAL THERAPY	.320577	30321	9720	51
52 SPEECH PATHOLOGY	.295460	18711	5528	52
53 ELECTROCARDIOLOGY	.909746			53
55 MEDICAL SUPPLIES CHARGED TO PAT	.269359	381658	102803	55
56 DRUGS CHARGED TO PATIENTS	.366954	943942	346383	56
59.97 CARDIAC REHABILITATION				59.97
59.98 HYPERBARIC OXYGEN THERAPY				59.98
59.99 LITHOTRIPSY				59.99
OUTPATIENT SERVICE COST CENTERS				
61 EMERGENCY	.409451			61
62 OBSERVATION BEDS (NON-DISTINCT OTHER REIMBURSABLE COST CENTERS	.848073			62
63.50 RHC	1.409159			63.50
63.60 FQHC				63.60
101 TOTAL		3064778	931609	101
102 LESS PBP CLINIC LAB SVCS-PGM ONLY CHARGES				102
103 NET CHARGES		3064778		103

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INPATIENT ANCILLARY COST APPORTIONMENT

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<input type="checkbox"/> TITLE V	<input type="checkbox"/> HOSPITAL	<input checked="" type="checkbox"/> SNF (14-5528)	<input checked="" type="checkbox"/> PPS
<input checked="" type="checkbox"/> TITLE XVIII-FT A	<input type="checkbox"/> SUB I	<input type="checkbox"/> NF	<input type="checkbox"/> TEFRA
<input type="checkbox"/> TITLE XIX	<input type="checkbox"/> SUB II	<input type="checkbox"/> S/B-SNF	<input type="checkbox"/> OTHER
	<input type="checkbox"/> SUB III	<input type="checkbox"/> S/B-NF	
	<input type="checkbox"/> SUB IV	<input type="checkbox"/> ICF/MR	

COST CENTER DESCRIPTION	RATIO OF COST TO CHARGES 1	INPATIENT PROGRAM CHARGES 2	INPATIENT PROGRAM COSTS 3	
INPATIENT ROUTINE SERVICE COST CENTERS				
25 ADULTS & PEDIATRICS				25
ANCILLARY SERVICE COST CENTERS				
37 OPERATING ROOM	.273980			37
38 RECOVERY ROOM				38
40 ANESTHESIOLOGY				40
41 RADIOLOGY-DIAGNOSTIC	.196643	3368	662	41
44 LABORATORY	.218689	6604	1444	44
46.30 BLOOD CLOTTING FACTORS ADMIN CO				46.30
49 RESPIRATORY THERAPY	.145830	15647	2282	49
50 PHYSICAL THERAPY	.303036	32170	9749	50
51 OCCUPATIONAL THERAPY	.320577	16655	5339	51
52 SPEECH PATHOLOGY	.295460	1439	425	52
53 ELECTROCARDIOLOGY	.909746			53
55 MEDICAL SUPPLIES CHARGED TO PAT	.269359	7061	1902	55
56 DRUGS CHARGED TO PATIENTS	.366954	52477	19257	56
59.97 CARDIAC REHABILITATION				59.97
59.98 HYPERBARIC OXYGEN THERAPY				59.98
59.99 LITHOTRIPSY				59.99
OUTPATIENT SERVICE COST CENTERS				
61 EMERGENCY	.409451			61
62 OBSERVATION BEDS (NON-DISTINCT	.848073			62
OTHER REIMBURSABLE COST CENTERS				
63.50 RHC	1.409159			63.50
63.60 FQHC				63.60
101 TOTAL		135421	41060	101
102 LESS PBP CLINIC LAB SVCS-PGM ONLY CHARGES				102
103 NET CHARGES		135421		103

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INPATIENT ANCILLARY COST APPORTIONMENT

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<input type="checkbox"/> TITLE V	<input type="checkbox"/> HOSPITAL	<input type="checkbox"/> SNF	<input type="checkbox"/> PPS
<input checked="" type="checkbox"/> TITLE XVIII-PT A	<input type="checkbox"/> SUB I	<input type="checkbox"/> NF	<input type="checkbox"/> TEFRA
<input type="checkbox"/> TITLE XIX	<input type="checkbox"/> SUB II	<input checked="" type="checkbox"/> S/B-SNF (14-Z318)	<input checked="" type="checkbox"/> OTHER
	<input type="checkbox"/> SUB III	<input type="checkbox"/> S/B-NF	
	<input type="checkbox"/> SUB IV	<input type="checkbox"/> ICF/MR	

COST CENTER DESCRIPTION	RATIO OF COST TO CHARGES 1	INPATIENT PROGRAM CHARGES 2	INPATIENT PROGRAM COSTS 3	
INPATIENT ROUTINE SERVICE COST CENTERS				
25 ADULTS & PEDIATRICS				25
ANCILLARY SERVICE COST CENTERS				
37 OPERATING ROOM	.273980			37
38 RECOVERY ROOM				38
40 ANESTHESIOLOGY				40
41 RADIOLOGY-DIAGNOSTIC	.196643	52062	10238	41
44 LABORATORY	.218689	93318	20408	44
46.30 BLOOD CLOTTING FACTORS ADMIN CO				46.30
49 RESPIRATORY THERAPY	.145830	75156	10960	49
50 PHYSICAL THERAPY	.303036	246361	74656	50
51 OCCUPATIONAL THERAPY	.320577	143560	46022	51
52 SPEECH PATHOLOGY	.295460	9427	2785	52
53 ELECTROCARDIOLOGY	.909746	3753	3414	53
55 MEDICAL SUPPLIES CHARGED TO PAT	.269359	68177	18364	55
56 DRUGS CHARGED TO PATIENTS	.366954	456023	167339	56
59.97 CARDIAC REHABILITATION				59.97
59.98 HYPERBARIC OXYGEN THERAPY				59.98
59.99 LITHOTRIPSY				59.99
OUTPATIENT SERVICE COST CENTERS				
61 EMERGENCY	.409451			61
62 OBSERVATION BEDS (NON-DISTINCT OTHER REIMBURSABLE COST CENTERS	.848073			62
63.50 RHC	1.409159			63.50
63.60 FQHC				63.60
101 TOTAL		1147837	354186	101
102 LESS PBP CLINIC LAB SVCS-PGM ONLY CHARGES				102
103 NET CHARGES		1147837		103

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INPATIENT ANCILLARY COST APPORTIONMENT

WORKSHEET D-4

<input type="checkbox"/> TITLE V	<input checked="" type="checkbox"/> HOSPITAL (14-1318)	<input type="checkbox"/> SNF	<input checked="" type="checkbox"/> PPS
<input type="checkbox"/> TITLE XVIII-PT A	<input type="checkbox"/> SUB I	<input type="checkbox"/> NF	<input type="checkbox"/> TEFRA
<input checked="" type="checkbox"/> TITLE XIX	<input type="checkbox"/> SUB II	<input type="checkbox"/> S/B-SNF	<input type="checkbox"/> OTHER
	<input type="checkbox"/> SUB III	<input type="checkbox"/> S/B-NF	
	<input type="checkbox"/> SUB IV	<input type="checkbox"/> ICF/MR	

COST CENTER DESCRIPTION	RATIO OF COST TO CHARGES 1	INPATIENT PROGRAM CHARGES 2	INPATIENT PROGRAM COSTS 3
INPATIENT ROUTINE SERVICE COST CENTERS			
25 ADULTS & PEDIATRICS			25
ANCILLARY SERVICE COST CENTERS			
37 OPERATING ROOM	.273980		37
38 RECOVERY ROOM			38
40 ANESTHESIOLOGY			40
41 RADIOLOGY-DIAGNOSTIC	.196643		41
44 LABORATORY	.218689		44
46.30 BLOOD CLOTTING FACTORS ADMIN CO			46.30
49 RESPIRATORY THERAPY	.145830		49
50 PHYSICAL THERAPY	.304554		50
51 OCCUPATIONAL THERAPY	.320577		51
52 SPEECH PATHOLOGY	.295460		52
53 ELECTROCARDIOLOGY	.909746		53
55 MEDICAL SUPPLIES CHARGED TO PAT	.269359		55
56 DRUGS CHARGED TO PATIENTS	.366954		56
59.97 CARDIAC REHABILITATION			59.97
59.98 HYPERBARIC OXYGEN THERAPY			59.98
59.99 LITHOTRIPSY			59.99
OUTPATIENT SERVICE COST CENTERS			
61 EMERGENCY	.409451		61
62 OBSERVATION BEDS (NON-DISTINCT OTHER REIMBURSABLE COST CENTERS	.848073		62
63.50 RHC	1.409159		63.50
63.60 FQHC			63.60
101 TOTAL			101
102 LESS PBP CLINIC LAB SVCS-PGM ONLY CHARGES			102
103 NET CHARGES			103

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CALCULATION OF REIMBURSEMENT SETTLEMENT

WORKSHEET E
 PART A

PART A - INPATIENT HOSPITAL SERVICES UNDER PPS

HOSPITAL SUB I SUB II SUB III SUB IV

DRG AMOUNT					
1 OTHER THAN OUTLIER PAYMENTS OCCURRING BEFORE OCTOBER 1					1
1.01 OTHER THAN OUTLIER PAYMENTS OCCURRING ON OR AFTER OCTOBER 1 AND BEFORE JANUARY 1					1.01
1.02 OTHER THAN OUTLIER PAYMENTS OCCURRING ON OR AFTER JAN 1 MANAGED CARE PATIENTS					1.02
1.03 PAYMENTS PRIOR TO MARCH 1 OR OCTOBER 1					1.03
1.04 PAYMENTS ON OR AFTER OCTOBER 1 AND PRIOR TO JANUARY 1					1.04
1.05 PAYMENTS ON OR AFTER JAN 1 BUT BEFORE APR 1/OCT 1					1.05
1.06 ADDITIONAL AMOUNT RECEIVED OR TO BE RECEIVED					1.06
1.07 PAYMENTS FOR DISCHARGES ON OR AFTER APRIL 1, 2001 THROUGH SEPTEMBER 30, 2001					1.07
1.08 SIMULATED PAYMENTS FROM THE PS&R ON OR AFTER APRIL 1, 2001 THROUGH SEPTEMBER 30, 2001					1.08
2 OUTLIER PAYMENTS PRIOR TO OCTOBER 1, 1997					2
2.01 OUTLIER PAYMENTS ON OR AFTER OCTOBER 1, 1997 INDIRECT MEDICAL EDUCATION ADJUSTMENT					2.01
3 BED DAYS AVAILABLE DIVIDED BY NO. OF DAYS IN CR PERIOD					3
3.01 NO OF INTERNS & RESIDENTS FROM WORKSHEET S-3, PART I					3.01
3.02 INDIRECT MEDICAL EDUCATION PERCENTAGE					3.02
3.03 INDIRECT MEDICAL EDUCATION ADJUSTMENT					3.03
3.04 FTE COUNT FOR ALLOPATHIC AND OSTEOPATHIC PGMS FOR THE MOST RECENT CR PERIOD ENDING ON OR BEFORE DEC 31, 1996					3.04
3.05 FTE COUNT FOR ALLOPATHIC AND OSTEOPATHIC PGMS WHICH MEET THE CRITERIA FOR AN ADD-ON TO THE CAP FOR NEW PROGRAMS IN ACCORDANCE WITH SECTION 1886(d)(5)(B)(viii)					3.05
3.06 ADJUSTED FTE COUNT FOR ALLOPATHIC AND OSTEOPATHIC PGMS FOR AFFILIATED PROGRAMS IN ACCORDANCE WITH SECTION 1886(d)(5)(B)(viii) [FOR CR PERIODS ENDING] [ON OR AFTER 7/1/2005] [E-3,PT.VI, LN.15][PLUS LN.3.06]					3.06
3.07 SUM OF LINES 3.04-3.06 0.00 0.00					3.07
3.08 FTE COUNT FOR ALLOPATHIC AND OSTEOPATHIC PROGRAMS IN THE CURRENT YEAR FROM YOUR RECORDS					3.08
3.09 FOR CR PERIODS BEGINNING BEFORE OCTOBER 1, ENTER THE PERCENTAGE OF DISCHARGES OCCURRING PRIOR TO OCTOBER 1					3.09
3.10 FOR CR PERIODS BEGINNING BEFORE OCTOBER 1, ENTER THE PERCENTAGE OF DISCHARGES OCCURRING ON OR AFTER OCT. 1					3.10
3.11 FTE COUNT FOR THE PERIOD IDENTIFIED IN LINE 3.09					3.11
3.12 FTE COUNT FOR THE PERIOD IDENTIFIED IN LINE 3.10					3.12
3.13 FTE COUNT FOR RESIDENTS IN DENTAL & PODIATRIC PROGRAMS					3.13
3.14 CURRENT YEAR ALLOWABLE FTE					3.14
3.15 TOTAL ALLOWABLE FTE COUNT FOR THE PRIOR YEAR, IF NONE BUT PRIOR YEAR TEACHING WAS IN EFFECT ENTER 1 HERE..					3.15
3.16 TOTAL ALLOWABLE FTE COUNT FOR THE PENULTIMATE YEAR IF THAT YEAR ENDED ON OR AFTER SEPTEMBER 30, 1997, OTHERWISE ENTER ZERO. IF THERE WAS NO FTE COUNT IN THIS PERIOD BUT PRIOR YR TEACHING WAS IN EFFECT ENTER 1 HERE..					3.16
RES. IN INIT YRS					
3.17 SUM OF LINES 3.14 THROUGH 3.16 DIVIDED BY THE 0.00 NUMBER OF THOSE LINES IN EXCESS OF ZERO					3.17

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WORKSHEET E
 PART A
 (CONT)

PART A - INPATIENT HOSPITAL SERVICES UNDER PPS

HOSPITAL SUB I SUB II SUB III SUB IV

3.18	CURRENT YEAR RESIDENT TO BED RATIO					3.18
3.19	PRIOR YEAR RESIDENT TO BED RATIO					3.19
3.20	FOR COST REPORTING PERIODS BEGINNING ON OR AFTER OCTOBER 1, 1997, ENTER THE LESSER OF LINES 3.18 OR 3.19					3.20
3.21	IME PAYMENTS FOR DSCHGS OCCURRING PRIOR TO OCTOBER 1					3.21
3.22	IME PAYMENTS FOR DSCHGS AFTER SEP 30 BUT BEFORE JAN 1					3.22
3.23	IME PAYMENTS FOR DSCHGS OCCURRING ON OR AFTER JANUARY 1 [SUM OF LINES][PLUS E-3,PT.VI] [3.21-3.23][LINE 23]					3.23
3.24	SUM OF LINES 3.21-3.23 DISPROPORTIONATE SHARE ADJUSTMENT	0	0			3.24
4	PERCENTAGE OF SSI RECIPIENT PATIENT DAYS TO MEDICARE PART A PATIENT DAYS					4
4.01	PERCENTAGE OF MEDICAID PATIENT DAYS TO TOTAL DAYS					4.01
4.02	SUM OF 4 AND 4.01					4.02
4.03	ALLOWABLE DISPROPORTIONATE SHARE PERCENTAGE					4.03
4.04	DISPROPORTIONATE SHARE ADJUSTMENT					4.04
5	ADDITIONAL PAYMENT FOR HIGH PERCENTAGE OF ESRD BENEFICIARY DISCHARGES					5
5.01	TOTAL MEDICARE DISCHARGES ON WKST S-3, PART I EXCLUDING DISCHARGES FOR DRGs 302, 316 AND 317					5.01
5.02	TOTAL ESRD MEDICARE DISCHARGES EXCLUDING DRGs 302, 316 AND 317					5.02
5.03	DIVIDE LINE 5.01 BY LINE 5					5.03
5.04	TOTAL MEDICARE ESRD INPATIENT DAYS EXCLUDING DRGs 302, 316 AND 317					5.04
5.05	RATIO OF AVERAGE LENGTH OF STAY TO ONE WEEK					5.05
5.06	AVERAGE WEEKLY COST FOR DIALYSIS TREATMENTS					5.06
6	TOTAL ADDITIONAL PAYMENT					6
7	SUBTOTAL					7
7.01	HOSPITAL SPECIFIC PAYMENTS					7.01
8	HOSPITAL SPECIFIC PAYMENTS (1996 HSR)					8
9	TOTAL PAYMENT FOR INPATIENT OPERATING COSTS					9
10	PAYMENT FOR INPATIENT PROGRAM CAPITAL					10
11	EXCEPTION PAYMENT FOR INPATIENT PROGRAM CAPITAL					11
11.01	DIRECT GRADUATE MEDICAL EDUCATION PAYMENT					11.01
11.02	NURSING AND ALLIED HEALTH MANAGED CARE					11.02
12	ADD-ON PAYMENT FOR NEW TECHNOLOGIES					12
13	NET ORGAN ACQUISITION COST					13
14	COST OF TEACHING PHYSICIANS					14
15	ROUTINE SERVICE OTHER PASS THROUGH COSTS					15
16	ANCILLARY SERVICE OTHER PASS THROUGH COSTS					16
17	TOTAL					17
18	PRIMARY PAYER PAYMENTS					18
19	TOTAL AMOUNT PAYABLE FOR PROGRAM BENEFICIARIES					19
20	DEDUCTIBLES BILLED TO PROGRAM BENEFICIARIES					20
21	COINSURANCE BILLED TO PROGRAM BENEFICIARIES					21
21.01	REIMBURSABLE BAD DEBTS					21.01
21.02	REDUCED PROGRAM REIMBURSABLE BAD DEBTS					21.02
22	REIMBURSABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES					22
	SUBTOTAL					

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WORKSHEET E
PART A
(CONT)

PART A - INPATIENT HOSPITAL SERVICES UNDER PPS

	HOSPITAL	SUB I	SUB II	SUB III	SUB IV	
23	RECOVERY OF EXCESS DEPRECIATION RESULTING FROM PROVIDER TERMINATION OR A DECREASE IN PROGRAM UTILIZATION					23
24	OTHER ADJUSTMENTS					24
25	AMOUNTS APPLICABLE TO PRIOR COST REPORTING PERIODS RESULTING FROM DISPOSITION OF DEPRECIABLE ASSETS					25
26	AMOUNT DUE PROVIDER					26
27	SEQUESTRATION ADJUSTMENT					27
28	INTERIM PAYMENTS					28
28.01	TENTATIVE SETTLEMENT (FOR FI USE ONLY)					28.01
29	BALANCE DUE PROVIDER (PROGRAM)					29
30	PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS) IN ACCORDANCE WITH CMS PUB 15-II, SECTION 115.2					30
TO BE COMPLETED BY INTERMEDIARY						
50	OPERATING OUTLIER AMOUNT FROM WKST E, PART A, LINE 2.01					50
51	CAPITAL OUTLIER AMOUNT FROM WKST L, PART I, LINE 3.01					51
52	OPERATING OUTLIER RECONCILIATION AMOUNT (SEE INSTR.)					52
53	CAPITAL OUTLIER RECONCILIATION AMOUNT (SEE INSTRUCTIONS)					53
54	THE RATE USED TO CALCULATE THE TIME VALUE OF MONEY					54
55	TIME VALUE OF MONEY (SEE INSTRUCTIONS)					55
56	CAPITAL TIME VALUE OF MONEY (SEE INSTRUCTIONS)					56

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CALCULATION OF REIMBURSEMENT SETTLEMENT

WORKSHEET E
PART B

PART B - MEDICAL AND OTHER HEALTH SERVICES

	HOSPITAL (14-1318) 1	HOSPITAL (14-1318) 1.01	HOSPITAL (14-1318) 1.02	
1 MEDICAL AND OTHER SERVICES	2932668			1
1.01 MEDICAL AND OTHER SERVICES RENDERED ON OR AFTER AUGUST 1, 2000				1.01
1.02 PPS PAYMENTS RECEIVED INCLUDING OUTLIERS				1.02
1.03 1996 HOSPITAL SPECIFIC PAYMENT TO COST RATIO				1.03
1.04 LINE 1.01 TIMES LINE 1.03				1.04
1.05 LINE 1.02 DIVIDED BY LINE 1.04				1.05
1.06 TRANSITIONAL CORRIDOR PAYMENT				1.06
1.07 AMOUNT FROM WORKSHEET D, PART IV, COLUMN 9, LINE 101				1.07
2 INTERNS AND RESIDENTS				2
3 ORGAN ACQUISITIONS				3
4 COST OF TEACHING PHYSICIANS				4
5 TOTAL COST	2932668			5
COMPUTATION OF LESSER OF COST OR CHARGES REASONABLE CHARGES				
6 ANCILLARY SERVICE CHARGES				6
7 INTERNS AND RESIDENTS SERVICE CHARGES				7
8 ORGAN ACQUISITION CHARGES				8
9 CHARGES OF PROFESSIONAL SERVICES OF TEACHING PHYSICIANS				9
10 TOTAL REASONABLE CHARGES				10
CUSTOMARY CHARGES				
11 AGGREGATE AMOUNT ACTUALLY COLLECTED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICES ON A CHARGE BASIS				11
12 AMOUNTS THAT WOULD HAVE BEEN REALIZED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICES ON A CHARGE BASIS HAD SUCH PAYMENT BEEN MADE IN ACCORDANCE WITH 42 CFR 413.13(E)				12
13 RATIO OF LINE 11 TO LINE 12				13
14 TOTAL CUSTOMARY CHARGES				14
15 EXCESS OF CUSTOMARY CHGES OVER REASONABLE COST				15
16 EXCESS OF REASONABLE COST OVER CUSTOMARY CHARGES				16
17 LESSER OF COST OR CHARGES	2961995			17
17.01 TOTAL PPS PAYMENTS				17.01

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WORKSHEET E
 PART B

PART B - MEDICAL AND OTHER HEALTH SERVICES

	HOSPITAL (14-1318) 1	HOSPITAL (14-1318) 1.01	HOSPITAL (14-1318) 1.02
COMPUTATION OF REIMBURSEMENT SETTLEMENT			
18 DEDUCTIBLES	20666		18
18.01 COINSURANCE	1495242		18.01
19 SUBTOTAL	1446087		19
20 SUM OF AMOUNTS FROM WKST E, PARTS C,D & E			20
21 DIRECT GRADUATE MEDICAL EDUCATION PAYMENTS			21
22 ESRD DIRECT MEDICAL EDUCATION COSTS			22
23 SUBTOTAL	1446087		23
24 PRIMARY PAYER PAYMENTS	66		24
25 SUBTOTAL	1446021		25
REIMBURSABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)			
26 COMPOSITE RATE ESRD			26
27 BAD DEBTS	341577		27
27.01 REDUCED REIMBURSABLE BAD DEBTS	341577		27.01
27.02 REIMBURSABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES (SEE INSTRUCTIONS)	295426		27.02
28 SUBTOTAL	1787598		28
29 RECOVERY OF EXCESS DEPRECIATION RESULTING FROM PROVIDER TERMINATION OR A DECREASE IN PROGRAM UTILIZATION			29
30 OTHER ADJUSTMENTS			30
30.99 OTHER ADJUSTMENTS (MSP-LCC RECONCILIATION AMOUNT)			30.99
31 AMOUNTS APPLICABLE TO PRIOR COST REPORTING PERIODS RESULTING FROM DISPOSITION OF DEPRECIABLE ASSETS			31
32 SUBTOTAL	1787598		32
33 SEQUESTRATION ADJUSTMENT			33
34 INTERIM PAYMENTS	1914376		34
34.01 TENTATIVE SETTLEMENT (FOR FI USE ONLY)			34.01
35 BALANCE DUE PROVIDER/PROGRAM	-126778		35
36 PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS) IN ACCORDANCE WITH CMS PUB 15-II, SECTION 115.2	30515		36
TO BE COMPLETED BY CONTRACTOR			
50 ORIGINAL OUTLIER AMOUNT (SEE INSTRUCTIONS)			50
51 OUTLIER RECONILIATION AMOUNT (SEE INSTRUCT			51
52 THE RATE USED TO CALCULATE THE TIME VALUE			52
53 TIME VALUE OF MONEY (SEE INSTRUCTIONS)			53
54 TOTAL (SUM OF LINES 51 AND 53)			54

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CALCULATION OF REIMBURSEMENT SETTLEMENT

WORKSHEET E
PART B

PART B - MEDICAL AND OTHER HEALTH SERVICES

	SNF (14-5528) 1	SNF (14-5528) 1.01	SNF (14-5528) 1.02	
1 MEDICAL AND OTHER SERVICES				1
1.01 MEDICAL AND OTHER SERVICES RENDERED ON OR AFTER AUGUST 1, 2000				1.01
1.02 PPS PAYMENTS RECEIVED INCLUDING OUTLIERS				1.02
1.03 1996 HOSPITAL SPECIFIC PAYMENT TO COST RATIO				1.03
1.04 LINE 1.01 TIMES LINE 1.03				1.04
1.05 LINE 1.02 DIVIDED BY LINE 1.04				1.05
1.06 TRANSITIONAL CORRIDOR PAYMENT				1.06
1.07 AMOUNT FROM WORKSHEET D, PART IV, COLUMN 9, LINE 101				1.07
2 INTERNS AND RESIDENTS				2
3 ORGAN ACQUISITIONS				3
4 COST OF TEACHING PHYSICIANS				4
5 TOTAL COST				5
COMPUTATION OF LESSER OF COST OR CHARGES REASONABLE CHARGES				
6 ANCILLARY SERVICE CHARGES				6
7 INTERNS AND RESIDENTS SERVICE CHARGES				7
8 ORGAN ACQUISITION CHARGES				8
9 CHARGES OF PROFESSIONAL SERVICES OF TEACHING PHYSICIANS				9
10 TOTAL REASONABLE CHARGES				10
CUSTOMARY CHARGES				
11 AGGREGATE AMOUNT ACTUALLY COLLECTED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICES ON A CHARGE BASIS				11
12 AMOUNTS THAT WOULD HAVE BEEN REALIZED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICES ON A CHARGE BASIS HAD SUCH PAYMENT BEEN MADE IN ACCORDANCE WITH 42 CFR 413.13(E)				12
13 RATIO OF LINE 11 TO LINE 12				13
14 TOTAL CUSTOMARY CHARGES				14
15 EXCESS OF CUSTOMARY CHGES OVER REASONABLE COST				15
16 EXCESS OF REASONABLE COST OVER CUSTOMARY CHARGES				16
17 LESSER OF COST OR CHARGES				17
17.01 TOTAL PPS PAYMENTS				17.01

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CALCULATION OF REIMBURSEMENT SETTLEMENT

WORKSHEET E
PART B

PART B - MEDICAL AND OTHER HEALTH SERVICES

	SNF (14-5528) 1	SNF (14-5528) 1.01	SNF (14-5528) 1.02
COMPUTATION OF REIMBURSEMENT SETTLEMENT			
18 DEDUCTIBLES			18
18.01 COINSURANCE			18.01
19 SUBTOTAL			19
20 SUM OF AMOUNTS FROM WKST E, PARTS C,D & E			20
21 DIRECT GRADUATE MEDICAL EDUCATION PAYMENTS			21
22 ESRD DIRECT MEDICAL EDUCATION COSTS			22
23 SUBTOTAL			23
24 PRIMARY PAYER PAYMENTS			24
25 SUBTOTAL			25
REIMBURSABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)			
26 COMPOSITE RATE ESRD			26
27 BAD DEBTS			27
27.01 REDUCED REIMBURSABLE BAD DEBTS			27.01
27.02 REIMBURSABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES (SEE INSTRUCTIONS)			27.02
28 SUBTOTAL			28
29 RECOVERY OF EXCESS DEPRECIATION RESULTING FROM PROVIDER TERMINATION OR A DECREASE IN PROGRAM UTILIZATION			29
30 OTHER ADJUSTMENTS			30
30.99 OTHER ADJUSTMENTS (MSP-LCC RECONCILIATION AMOUNT)			30.99
31 AMOUNTS APPLICABLE TO PRIOR COST REPORTING PERIODS RESULTING FROM DISPOSITION OF DEPRECIABLE ASSETS			31
32 SUBTOTAL			32
33 SEQUESTRATION ADJUSTMENT			33
34 INTERIM PAYMENTS			34
34.01 TENTATIVE SETTLEMENT (FOR FI USE ONLY)			34.01
35 BALANCE DUE PROVIDER/PROGRAM			35
36 PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS) IN ACCORDANCE WITH CMS PUB 15-II, SECTION 115.2			36
TO BE COMPLETED BY CONTRACTOR			
50 ORIGINAL OUTLIER AMOUNT (SEE INSTRUCTIONS)			50
51 OUTLIER RECONILIATION AMOUNT (SEE INSTRUCT			51
52 THE RATE USED TO CALCULATE THE TIME VALUE			52
53 TIME VALUE OF MONEY (SEE INSTRUCTIONS)			53
54 TOTAL (SUM OF LINES 51 AND 53)			54

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ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED
HOSPITAL (14-1318)

WORKSHEET E-1

		INPATIENT		PART B	
DESCRIPTION		MM/DD/YYYY	AMOUNT	MM/DD/YYYY	AMOUNT
		1	2	3	4
1 TOTAL INTERIM PAYMENTS PAID TO PROVIDER			1352829		1910918
2 INTERIM PAYMENTS PAYABLE ON INDIVIDUAL BILLS EITHER SUBMITTED OR TO BE SUBMITTED TO THE INTERMEDIARY FOR SERVICES RENDERED IN THE COST REPORTING PERIOD. IF NONE, WRITE 'NONE', OR ENTER A ZERO.			NONE		NONE
3 LIST SEPARATELY EACH RETROACTIVE LUMP SUM					
ADJUSTMENT AMOUNT BASED ON SUBSEQUENT	PROGRAM	.01 05/01/2009	57340	05/01/2009	60117
REVISION OF THE INTERIM RATE FOR THE COST	TO	.02 09/15/2009	15599		
REPORTING PERIOD. ALSO SHOW DATE OF EACH	PROVIDER	.03			
PAYMENT. IF NONE, WRITE 'NONE' OR ENTER A ZERO.		.04			
		.05			
		.50 09/15/2009	5013	05/01/2009	23350
	PROVIDER	.51		09/15/2009	33309
	TO	.52			
	PROGRAM	.53			
		.54			
SUBTOTAL		.99	67926		3458
4 TOTAL INTERIM PAYMENTS			1420755		1914376
TO BE COMPLETED BY INTERMEDIARY					
5 LIST SEPARATELY EACH TENTATIVE SETTLEMENT PAY- MENT AFTER DESK REVIEW. ALSO SHOW DATE OF EACH PAYMENT. IF NONE, WRITE 'NONE' OR ENTER A ZERO.	PROGRAM	.01			5.01
	TO	.02			5.02
	PROVIDER	.03			5.03
	PROVIDER	.50			5.50
	TO	.51			5.51
	PROGRAM	.52			5.52
SUBTOTAL		.99			5.99
6 DETERMINED NET SETTLEMENT AMOUNT (BALANCE DUE) BASED ON THE COST REPORT.	PROGRAM TO				
	PROVIDER	.01			6.01
	PROVIDER TO	.02			6.02
	PROGRAM				
7 TOTAL MEDICARE PROGRAM LIABILITY					7

NAME OF INTERMEDIARY:

INTERMEDIARY NUMBER:

SIGNATURE OF AUTHORIZED PERSON:

DATE (MO/DAY/YR):

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WORKSHEET E-1

DATE (MO/DAY/YR) :

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ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED
SWING BED SKILLED NURSING FACILITY (14-2318)

WORKSHEET E-1

DESCRIPTION	INPATIENT PART A		PART B	
	MM/DD/YYYY	AMOUNT	MM/DD/YYYY	AMOUNT
	1	2	3	4
1 TOTAL INTERIM PAYMENTS PAID TO PROVIDER		960544		1
2 INTERIM PAYMENTS PAYABLE ON INDIVIDUAL BILLS EITHER SUBMITTED OR TO BE SUBMITTED TO THE INTERMEDIARY FOR SERVICES RENDERED IN THE COST REPORTING PERIOD. IF NONE, WRITE 'NONE', OR ENTER A ZERO.		NONE	NONE	2
3 LIST SEPARATELY EACH RETROACTIVE LUMP SUM ADJUSTMENT AMOUNT BASED ON SUBSEQUENT REVISION OF THE INTERIM RATE FOR THE COST REPORTING PERIOD. ALSO SHOW DATE OF EACH PAYMENT. IF NONE, WRITE 'NONE' OR ENTER A ZERO.	.01 09/15/2009	86058		3.01
PROGRAM .02				3.02
TO .03			NONE	3.03
PROVIDER .04				3.04
.05				3.05
.50				3.50
PROVIDER .51				3.51
TO .52		NONE	NONE	3.52
PROGRAM .53				3.53
.54				3.54
SUBTOTAL .99		86058		3.99
4 TOTAL INTERIM PAYMENTS		1046602		4
TO BE COMPLETED BY INTERMEDIARY				
5 LIST SEPARATELY EACH TENTATIVE SETTLEMENT PAY- MENT AFTER DESK REVIEW. ALSO SHOW DATE OF EACH PAYMENT. IF NONE, WRITE 'NONE' OR ENTER A ZERO.	PROGRAM .01			5.01
	TO .02			5.02
	PROVIDER .03			5.03
	PROVIDER .50			5.50
	TO .51			5.51
	PROGRAM .52			5.52
SUBTOTAL .99				5.99
6 DETERMINED NET SETTLEMENT AMOUNT (BALANCE DUE) BASED ON THE COST REPORT.	PROGRAM TO .01			6.01
	PROVIDER TO .02			6.02
	PROGRAM			
7 TOTAL MEDICARE PROGRAM LIABILITY				7

NAME OF INTERMEDIARY:

INTERMEDIARY NUMBER:

SIGNATURE OF AUTHORIZED PERSON:

DATE (MO/DAY/YR):

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CALCULATION OF REIMBURSEMENT SETTLEMENT
 SWING BEDS

SUPPLEMENTAL
 WORKSHEET E-2

COMPUTATION OF NET COST OF COVERED SERVICES

	TITLE V S/B NF	--- TITLE XVIII ---		--- TITLE XIX ---	
		S/B SNF PART A	S/B SNF PART B (14-Z318)	S/B SNF (14-Z318)	S/B NF
	1	1	2	1	1
1 INPATIENT ROUTINE SERVICES - SWING BED - SNF		879685			1
2 INPATIENT ROUTINE SERVICES - SWING BED - NF					2
3 ANCILLARY SERVICES		357728			3
4 PER DIEM COST FOR INTERNS AND RESIDENTS NOT IN APPROVED TEACHING PROGRAM					4
5 PROGRAM DAYS		958			5
6 INTERNS AND RESIDENTS NOT IN APPROVED TEACHING PROGRAM					6
7 UTILIZATION REVIEW - PHYSICIAN COMPENSATION - SNF OPTIONAL METHOD ONLY					7
8 SUBTOTAL		1237413			8
9 PRIMARY PAYER PAYMENTS					9
10 SUBTOTAL		1237413			10
11 DEDUCTIBLES BILLED TO PROGRAM PATIENTS (EXCLUDE AMOUNTS APPLICABLE TO PHYSICIAN PROFESSIONAL SERVICES)					11
12 SUBTOTAL		1237413			12
13 COINSURANCE BILLED TO PROGRAM PATIENTS (EXCLUDE COINSURANCE FOR PHYSICIAN PROFESSIONAL SERVICES)		25297			13
14 80% OF PART B COSTS					14
15 SUBTOTAL		1212116			15
16 OTHER ADJUSTMENTS					16
17 REIMBURSABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PHYSICIAN PROFESSIONAL SERVICES)					17
17.01 REIMBURSABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES					17.01
18 TOTAL		1212116			18
19 SEQUESTRATION ADJUSTMENT					19
20 INTERIM PAYMENTS		1046602			20
20.01 TENTATIVE SETTLEMENT (FOR FI USE ONLY)					20.01
21 BALANCE DUE PROVIDER/PROGRAM		165514			21
22 PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS) IN ACCORDANCE WITH CMS PUB 15-11, SECTION 115.2		12752			22

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CALCULATION OF REIMBURSEMENT SETTLEMENT

WORKSHEET E-3
PART II

PART II - MEDICARE, PART A SERVICES - COST REIMBURSEMENT

	HOSPITAL (14-1318)	SUB I	SUB II	SUB III	SUB IV	SNF I
1 INPATIENT SERVICES	1840777					1
1.01 NURSING AND ALLIED HEALTH MANAGED CARE PAYMENT (SEE INSTRUCTIONS)						1.01
2 ORGAN ACQUISITION						2
3 COST OF TEACHING PHYSICIANS						3
4 SUBTOTAL	1840777					4
5 PRIMARY PAYER PAYMENTS						5
6 TOTAL COST	1859185					6
COMPUTATION OF LESSER OF COST OR CHARGES						
REASONABLE CHARGES						
7 ROUTINE SERVICE CHARGES						7
8 ANCILLARY SERVICE CHARGES						8
9 ORGAN ACQUISITION CHARGES, NET OF REVENUE						9
10 TEACHING PHYSICIANS						10
11 TOTAL REASONABLE CHARGES						11
12 AGGREGATE AMOUNT ACTUALLY COLLECTED FROM PATIENT LIABLE FOR PAYMENT FOR SERVICES ON A CHARGE BASIS						12
13 AMOUNT THAT WOULD HAVE BEEN REALIZED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICES ON A CHARGE BASIS HAD SUCH PAYMENT BEEN MADE IN ACCORDANCE WITH 42 CFR 413.13(E)						13
14 RATIO OF LINE 12 TO LINE 13						14
15 TOTAL CUSTOMARY CHARGES						15
16 EXCESS OF CUSTOMARY CHARGES OVER REASONABLE COST						16
17 EXCESS OF REASONABLE COST OVER CUSTOMARY CHARGES						17

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CALCULATION OF REIMBURSEMENT SETTLEMENT

WORKSHEET E-3
PART II

PART II - MEDICARE, PART A SERVICES - COST REIMBURSEMENT

	HOSPITAL (14-1318)	SUB I	SUB II	SUB III	SUB IV	SNF I
COMPUTATION OF REIMBURSEMENT SETTLEMENT						
18 DIRECT GRADUATE MEDICAL EDUCATION PAYMENTS						18
19 COST OF COVERED SERVICES	1859185					19
20 DEDUCTIBLES	274688					20
21 EXCESS REASONABLE COST						21
22 SUBTOTAL	1584497					22
23 COINSURANCE						23
24 SUBTOTAL	1584497					24
25 REIMBURSABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)	9097					25
25.01 REDUCED REIMBURSABLE BAD DEBTS	9097					25.01
25.02 REIMBURSABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES (SEE INSTRUCTIONS)	9097					25.02
26 SUBTOTAL	1593594					26
27 RECOVERY OF EXCESS DEPRECIATION RESULTING FROM PROVIDER TERMINATION OR A DECREASE IN PROGRAM UTILIZATION						27
28 AMOUNT TO ZERO OUT SNF						28
29 AMOUNTS APPLICABLE TO PRIOR COST REPORTING PERIODS RESULTING FROM DISPOSITION OF DEPRECIABLE ASSETS						29
30 SUBTOTAL	1593594					30
31 SEQUESTRATION ADJUSTMENT						31
32 INTERIM PAYMENTS	1420755					32
32.01 TENTATIVE SETTLEMENT (FOR FI USE ONLY)						32.01
33 BALANCE DUE PROVIDER/PROGRAM	172839					33
34 PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS) IN ACCORDANCE WITH CMS PUB 15-II, SECTION 115.2	19155					34

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CALCULATION OF REIMBURSEMENT SETTLEMENT

WORKSHEET E-3
PART III

PART III - TITLE V OR TITLE XIX SERVICES OR TITLE XVIII SNF PPS ONLY

[] TITLE V

[XX] TITLE XVIII

[] TITLE XIX

SNF I
(14-5528)
(PPS)
2

1	COMPUTATION OF NET COST OF COVERED SERVICES		1
2	INPATIENT HOSPITAL/SNF/NF SERVICES		2
3	MEDICAL AND OTHER SERVICES		3
4	INTERNS AND RESIDENTS		4
5	ORGAN ACQUISITION CERTIFIED TRANSPLANT CENTERS ONLY		5
6	COST OF TEACHING PHYSICIANS		6
7	SUBTOTAL		7
8	INPATIENT PRIMARY PAYER PAYMENTS		8
9	OUTPATIENT PRIMARY PAYER PAYMENTS		9
	SUBTOTAL		
10	COMPUTATION OF LESSER OF COST OR CHARGES		10
11	ROUTINE SERVICE CHARGES		11
12	ANCILLARY SERVICE CHARGES		12
13	INTERNS AND RESIDENTS SERVICE CHARGES		13
14	ORGAN ACQUISITION CHARGES, NET OF REVENUE		14
15	TEACHING PHYSICIANS		15
16	INCENTIVE FROM TARGET AMOUNT COMPUTATION		16
	TOTAL REASONABLE CHARGES		
17	CUSTOMARY CHARGES		17
18	AMOUNT ACTUALLY COLLECTED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICES ON A CHARGE BASIS		18
	AMOUNTS THAT WOULD HAVE BEEN REALIZED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICES ON A CHARGE BASIS HAD SUCH PAYMENT BEEN MADE IN ACCORDANCE WITH 42 CFR 413.13(E)		
19	RATIO OF LINE 17 TO LINE 18		19
20	TOTAL CUSTOMARY CHARGES		20
21	EXCESS OF CUSTOMARY CHARGES OVER REASONABLE COST		21
22	EXCESS OF REASONABLE COST OVER CUSTOMARY CHARGES		22
23	COST OF COVERED SERVICES		23
24	PROSPECTIVE PAYMENT AMOUNT		24
25	OTHER THAN OUTLIER PAYMENTS	77816	25
26	OUTLIER PAYMENTS		26
27	PROGRAM CAPITAL PAYMENTS		27
28	CAPITAL EXCEPTION PAYMENTS		28
29	ROUTINE SERVICE OTHER PASS THROUGH COSTS		29
30	ANCILLARY SERVICE OTHER PASS THROUGH COSTS		30
31	SUBTOTAL	77816	31
32	CUSTOMARY CHARGES (TITLE XIX PPS COVERED SERVICES ONLY)		32
33	AMOUNT FROM LINE 30	77816	33
	DEDUCTIBLES (EXCLUDE PROFESSIONAL COMPONENT)		

CALCULATION OF REIMBURSEMENT SETTLEMENT

WORKSHEET E-3
 PART III

PART III - TITLE V OR TITLE XIX SERVICES OR TITLE XVIII SNF PPS ONLY

[] TITLE V [XX] TITLE XVIII [] TITLE XIX

SNF I
 (14-552K)
 (PPS)
 2

COMPUTATION OF REIMBURSEMENT SETTLEMENT			
34	EXCESS OF REASONABLE COST		34
35	SUBTOTAL	77816	35
36	COINSURANCE	13090	36
37	SUM OF AMOUNTS FROM WKST E, PARTS C,D AND E, LINE 19		37
38	REIMBURSABLE BAD DEBTS		38
38.01	REDUCED REIMBURSABLE BAD DEBTS		38.01
38.02	REIMBURSABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES (SEE INSTRUCTIONS)		38.02
38.03	ADJUSTED REIMBURSABLE BAD DEBTS FOR PERIODS ENDING ON OR AFTER 10/01/05 (SEE INSTR.)		38.03
39	UTILIZATION REVIEW		39
40	SUBTOTAL	64726	40
41	INPATIENT ROUTINE SERVICE COST		41
42	MEDICARE INPATIENT ROUTINE CHARGES		42
43	AMOUNT ACTUALLY COLLECTED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICES ON A CHARGE BASIS		43
44	AMOUNTS THAT WOULD HAVE BEEN REALIZED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICES ON A CHARGE BASIS HAD SUCH PAYMENT BEEN MADE IN ACCORDANCE WITH 42 CFR 413.13(E)		44
45	RATIO OF LINE 43 TO LINE 44		45
46	TOTAL CUSTOMARY CHARGES		46
47	EXCESS OF CUSTOMARY CHARGES OVER REASONABLE COST		47
48	EXCESS OF REASONABLE COST OVER CUSTOMARY CHARGES		48
49	RECOVERY OF EXCESS DEPRECIATION RESULTING FROM PROVIDER TERMINATION OR A DECREASE IN PROGRAM UTILIZATION		49
50	AMOUNT TO ZERO OUT SNF		50
51	AMOUNTS APPLICABLE TO PRIOR COST REPORTING PERIODS RESULTING FROM DISPOSITION OF DEPRECIABLE ASSETS		51
52	SUBTOTAL	64726	52
53	INDIRECT MEDICAL EDUCATION ADJUSTMENT (PPS ONLY)		53
54	DIRECT GRADUATE MEDICAL EDUCATION PAYMENTS		54
55	TOTAL AMOUNT PAYABLE TO THE PROVIDER	64726	55
56	SEQUESTRATION ADJUSTMENT		56
57	INTERIM PAYMENTS	64726	57
57.01	TENTATIVE SETTLEMENT (FOR FI USE ONLY)		57.01
58	BALANCE DUE PROVIDER/PROGRAM		58
59	PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS) IN ACCORDANCE WITH CMS PUB 15-II, SECTION 115.2		59

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PART III - TITLE V OR TITLE XIX SERVICES OR TITLE XVIII SNF PPS ONLY

WORKSHEET E-3
PART III

[] TITLE V		[] TITLE XVIII		[XX] TITLE XIX			NF I (PPS)	
		HOSPITAL (14-1318) (PPS)	SUB I	SUB II	SUB III	SUB IV		
1	COMPUTATION OF NET COST OF COVERED SERVICES	1	1	1	1	1	1	1
2	INPATIENT HOSPITAL/SNF/NF SERVICES							2
3	MEDICAL AND OTHER SERVICES							3
4	INTERNS AND RESIDENTS							4
5	ORGAN ACQUISITION CERTIFIED TRANSPLANT CENTERS O							5
6	COST OF TEACHING PHYSICIANS							6
7	SUBTOTAL							7
8	INPATIENT PRIMARY PAYER PAYMENTS							8
9	OUTPATIENT PRIMARY PAYER PAYMENTS							9
10	SUBTOTAL							10
11	COMPUTATION OF LESSER OF COST OR CHARGES							11
12	ROUTINE SERVICE CHARGES							12
13	ANCILLARY SERVICE CHARGES							13
14	INTERNS AND RESIDENTS SERVICE CHARGES							14
15	ORGAN ACQUISITION CHARGES, NET OF REVENUE							15
16	TEACHING PHYSICIANS							16
17	INCENTIVE FROM TARGET AMOUNT COMPUTATION							17
18	TOTAL REASONABLE CHARGES							18
19	CUSTOMARY CHARGES							19
20	AMOUNT ACTUALLY COLLECTED FROM PATIENTS LIABLE							20
21	AMOUNTS THAT WOULD HAVE BEEN REALIZED FROM							21
22	A CHARGE BASIS HAD SUCH PAYMENT BEEN MADE IN							22
23	ACCORDANCE WITH 42 CFR 413.13(E)							23
24	RATIO OF LINE 17 TO LINE 18							24
25	TOTAL CUSTOMARY CHARGES							25
26	EXCESS OF CUSTOMARY CHARGES OVER REASONABLE COST							26
27	EXCESS OF REASONABLE COST OVER CUSTOMARY CHARGES							27
28	COST OF COVERED SERVICES							28
29	PROSPECTIVE PAYMENT AMOUNT							29
30	OTHER THAN OUTLIER PAYMENTS							30
31	OUTLIER PAYMENTS							31
32	PROGRAM CAPITAL PAYMENTS							32
33	CAPITAL EXCEPTION PAYMENTS							33
34	ROUTINE SERVICE OTHER PASS THROUGH COSTS							34
35	ANCILLARY SERVICE OTHER PASS THROUGH COSTS							35
36	SUBTOTAL							36
37	CUSTOMARY CHARGES (TITLE XIX PPS COVERED							37
38	LESSER OF LINES 30 OR 31							38
39	DEDUCTIBLES (EXCLUDE PROFESSIONAL COMPONENT)							39

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CALCULATION OF REIMBURSEMENT SETTLEMENT
PART III - TITLE V OR TITLE XIX SERVICES OR TITLE XVIII SNF PPS ONLY

WORKSHEET E-3
PART III

	[] TITLE V	[] TITLE XVIII	[XX] TITLE XIX	
	HOSPITAL (14-1318) (PPS)	SUB I	SUB II	SUB III SUB IV NF I
	1	1	1	1 1 1
COMPUTATION OF REIMBURSEMENT SETTLEMENT				
34 EXCESS OF REASONABLE COST				34
35 SUBTOTAL				35
36 COINSURANCE				36
37 SUM OF AMOUNTS FROM WKST E, PARTS C,D AND E,				37
38 REIMBURSABLE BAD DEBTS				38
38.01 REDUCED REIMBURSABLE BAD DEBTS				38.01
38.02 REIMBURSABLE BAD DEBTS FOR DUAL ELIGIBLE				38.02
BENEFICIARIES (SEE INSTRUCTIONS)				
39 UTILIZATION REVIEW				39
40 SUBTOTAL				40
41 INPATIENT ROUTINE SERVICE COST				41
42 MEDICARE INPATIENT ROUTINE CHARGES				42
43 AMOUNT ACTUALLY COLLECTED FROM PATIENTS LIABLE				43
44 AMOUNTS THAT WOULD HAVE BEEN REALIZED FROM				44
A CHARGE BASIS HAD SUCH PAYMENT BEEN MADE IN				
ACCORDANCE WITH 42 CFR 413.13(E)				
45 RATIO OF LINE 43 TO LINE 44				45
46 TOTAL CUSTOMARY CHARGES				46
47 EXCESS OF CUSTOMARY CHARGES OVER REASONABLE COST				47
48 EXCESS OF REASONABLE COST OVER CUSTOMARY CHARGES				48
49 RECOVERY OF EXCESS DEPRECIATION RESULTING FROM				49
UTILIZATION				
50 AMOUNT TO ZERO OUT SNF				50
51 AMOUNTS APPLICABLE TO PRIOR COST REPORTING				51
DEPRECIABLE ASSETS				
52 SUBTOTAL				52
53 INDIRECT MEDICAL EDUCATION ADJUSTMENT				53
54 DIRECT GRADUATE MEDICAL EDUCATION PAYMENTS				54
55 TOTAL AMOUNT PAYABLE TO THE PROVIDER				55
56 SEQUESTRATION ADJUSTMENT				56
57 INTERIM PAYMENTS				57
57.01 TENTATIVE SETTLEMENT (FOR FI USE ONLY)				57.01
58 BALANCE DUE PROVIDER/PROGRAM				58
59 PROTESTED AMOUNTS (NONALLOWABLE COST REPORT				59
SECTION 115.2				

BALANCE SHEET

WORKSHEET G

ASSETS		GENERAL FUND	SPECIFIC PURPOSE FUND	ENDOWMENT FUND	PLANT FUND
		1	2	3	4
CURRENT ASSETS					
1	CASH ON HAND AND IN BANKS	1473167			1
2	TEMPORARY INVESTMENTS				2
3	NOTES RECEIVABLE				3
4	ACCOUNTS RECEIVABLE	2902771			4
5	OTHER RECEIVABLES	806294			5
6	ALLOWANCE FOR UNCOLLECTIBLE NOTES & ACCOUNTS RECEIVABLE				6
7	INVENTORY	595264			7
8	PREPAID EXPENSES				8
9	OTHER CURRENT ASSETS	49626			9
10	DUE FROM OTHER FUNDS				10
11	TOTAL CURRENT ASSETS	5827122			11
FIXED ASSETS					
12	LAND	325000			12
12.01	ACCUMULATED DEPRECIATION				12.01
13	LAND IMPROVEMENTS	146120			13
13.01	ACCUMULATED DEPRECIATION	-68432			13.01
14	BUILDINGS	2607832			14
14.01	ACCUMULATED DEPRECIATION	-944921			14.01
15	LEASEHOLD IMPROVEMENTS				15
15.01	ACCUMULATED AMORTIZATION				15.01
16	FIXED EQUIPMENT				16
16.01	ACCUMULATED DEPRECIATION				16.01
17	AUTOMOBILES AND TRUCKS				17
17.01	ACCUMULATED DEPRECIATION				17.01
18	MAJOR MOVABLE EQUIPMENT	3854963			18
18.01	ACCUMULATED DEPRECIATION	-1841456			18.01
19	MINOR EQUIPMENT DEPRECIABLE				19
19.01	ACCUMULATED DEPRECIATION				19.01
20	MINOR EQUIPMENT-NONDEPRECIABLE				20
21	TOTAL FIXED ASSETS	4079106			21
OTHER ASSETS					
22	INVESTMENTS				22
23	DEPOSITS ON LEASES				23
24	DUE FROM OWNERS/OFFICERS				24
25	OTHER ASSETS	7254997			25
26	TOTAL OTHER ASSETS	7254997			26
27	TOTAL ASSETS	17161225			27
LIABILITIES AND FUND BALANCES		GENERAL FUND	SPECIFIC PURPOSE FUND	ENDOWMENT FUND	PLANT FUND
		1	2	3	4
CURRENT LIABILITIES					
28	ACCOUNTS PAYABLE	126920			28
29	SALARIES, WAGES & FEES PAYABLE	801343			29
30	PAYROLL TAXES PAYABLE				30
31	NOTES & LOANS PAYABLE (SHORT TERM)				31
32	DEFERRED INCOME				32
33	ACCELERATED PAYMENTS				33
34	DUE TO OTHER FUNDS	-452017			34
35	OTHER CURRENT LIABILITIES	1571087			35
36	TOTAL CURRENT LIABILITIES	2047333			36
LONG-TERM LIABILITIES					
37	MORTGAGE PAYABLE				37
38	NOTES PAYABLE				38
39	UNSECURED LOANS				39
40	LOANS FROM OWNERS .01 PRIOR TO 7/1/66 .02 ON OR AFTER 7/1/66				40
41	OTHER LONG TERM LIABILITIES	151850			41
42	TOTAL LONG TERM LIABILITIES	151850			42
43	TOTAL LIABILITIES	2199183			43
CAPITAL ACCOUNTS					
44	GENERAL FUND BALANCE	14962042			44
45	SPECIFIC PURPOSE FUND BALANCE				45
46	DONOR CREATED-ENDOWMENT FUND BAL-RESTRICTED				46
47	DONOR CREATED-ENDOWMENT FUND BAL-UNRESTRICTED				47
48	GOVERNING BODY CREATED - ENDOWMENT FUND BAL				48
49	PLANT FUND BALANCE - INVESTED IN PLANT				49
50	PLANT FUND BALANCE - RESERVE FOR PLANT IMPROVEMENT, REPLACEMENT AND EXPANSION				50
51	TOTAL FUND BALANCES	14962042			51
52	TOTAL LIABILITIES AND FUND BALANCES	17161225			52

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STATEMENT OF CHANGES IN FUND BALANCES

WORKSHEET G-1

	GENERAL FUND 1	SPECIFIC PURPOSE FUND 2	ENDOWMENT FUND 3	PLANT FUND 4
1 FUND BALANCES AT BEGINNING OF PERIOD	13164549			1
2 NET INCOME (LOSS)	1769784			2
3 TOTAL	14934333			3
4 ADDITIONS (CREDIT ADJUSTMENTS)	27708			4
5				5
6				6
7				7
8				8
9				9
10 TOTAL ADDITIONS	27708			10
11 SUBTOTAL	14962041			11
12 DEDUCTIONS (DEBIT ADJUSTMENTS)				12
13				13
14				14
15				15
16				16
17				17
18 TOTAL DEDUCTIONS				18
19 FUND BALANCE AT END OF PERIOD PER BALANCE SHEET	14962041			19

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STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

WORKSHEET G-2
 PARTS I & II

PART I - PATIENT REVENUES

REVENUE CENTER	INPATIENT 1	OUTPATIENT 2	TOTAL 3	
1 GENERAL INPATIENT ROUTINE CARE SERVICES				1
2 HOSPITAL	1719643		1719643	2
4 SUBPROVIDER I				4
5 SWING BED - SNF	694575		694575	5
6 SWING BED - NF				6
7 SKILLED NURSING FACILITY	1188018		1188018	7
8 NURSING FACILITY				8
9 OTHER LONG TERM CARE				9
10 TOTAL GENERAL INPATIENT CARE SERVICES	3602236		3602236	10
11 INTENSIVE CARE TYPE INPATIENT HOSPITAL SERVICES				11
12 INTENSIVE CARE UNIT				12
13 CORONARY CARE UNIT				13
14 BURN INTENSIVE CARE UNIT				14
15 SURGICAL INTENSIVE CARE UNIT				15
16 OTHER SPECIAL CARE (SPECIFY)				16
17 TOTAL INTENSIVE CARE TYPE INPATIENT HOSPITAL SERVICE				17
18 TOTAL INPATIENT ROUTINE CARE SERVICES	3602236		3602236	18
19 ANCILLARY SERVICES	6811324		6811324	19
20 OUTPATIENT SERVICES				20
21 RHC		35318858	35318858	21
22 FQHC		3750467	3750467	22
23 HOME HEALTH AGENCY				23
24 AMBULANCE				24
25 CORF				25
26 ASC				26
27 HOSPICE				27
28 TOTAL PATIENT REVENUES	10413560	39069325	49482885	28

PART II - OPERATING EXPENSES

	1	2	
26 OPERATING EXPENSES		22872365	26
27 ADD (SPECIFY)			27
28 BAD DEBT	1204249		28
29			29
30			30
31			31
32			32
33 TOTAL ADDITIONS		1204249	33
34 DEDUCT (SPECIFY)			34
35			35
36			36
37			37
38			38
39 TOTAL DEDUCTIONS			39
40 TOTAL OPERATING EXPENSES		24076614	40

STATEMENT OF REVENUES AND EXPENSES

WORKSHEET G-3

DESCRIPTION			
1	TOTAL PATIENT REVENUES	49482885	1
2	LESS - CONTRACTUAL ALLOWANCES AND DISCOUNTS ON PATIENTS' ACCOUNTS	23849160	2
3	NET PATIENT REVENUES	25633725	3
4	LESS - TOTAL OPERATING EXPENSES	24076614	4
5	NET INCOME FROM SERVICE TO PATIENTS	1557111	5
6	CONTRIBUTIONS, DONATIONS, BEQUESTS, ETC.	57332	6
7	INCOME FROM INVESTMENTS	7943	7
8	REVENUE FROM TELEPHONE AND TELEGRAPH SERVICE		8
9	REVENUE FROM TELEVISION AND RADIO SERVICE		9
10	PURCHASE DISCOUNTS		10
11	REBATES AND REFUNDS OF EXPENSES		11
12	PARKING LOT RECEIPTS		12
13	REVENUE FROM LAUNDRY AND LINEN SERVICE		13
14	REVENUE FROM MEALS SOLD TO EMPLOYEES AND GUESTS	36857	14
15	REVENUE FROM RENTAL OF LIVING QUARTERS		15
16	REV FROM SALE OF MED & SURG SUPP TO OTHER THAN PATIENTS		16
17	REVENUE FROM SALE OF DRUGS TO OTHER THAN PATIENTS		17
18	REVENUE FROM SALE OF MEDICAL RECORDS AND ABSTRACTS	6204	18
19	TUITION (FEES, SALE OF TEXTBOOKS, UNIFORMS, ETC.)		19
20	REVENUE FROM GIFTS, FLOWER, COFFEE SHOPS, CANTEEN		20
21	RENTAL OF VENDING MACHINES		21
22	RENTAL OF HOSPITAL SPACE	13915	22
23	GOVERNMENTAL APPROPRIATIONS		23
24	OTHER INCOME	59140	24
24.01	GRANT INCOME	29282	24.01
24.02	WORKERS COMP		24.02
25	TOTAL OTHER INCOME	212673	25
26	TOTAL	1769784	26
27			27
28			28
29			29
30	TOTAL OTHER EXPENSES		30
31	NET INCOME (OR LOSS) FOR THE PERIOD	1769784	31

CALCULATION OF CAPITAL PAYMENT - TITLE XIX - COST METHOD

WORKSHEET L

	HOSPITAL (14-1318)	SUB I	SUB II	SUB III	SUB IV
PART I - FULLY PROSPECTIVE METHOD					
1 CAPITAL HOSPITAL SPECIFIC RATE PAYMENTS					1
2 CAPITAL FEDERAL AMOUNT					2
3 CAPITAL DRG OTHER THAN OUTLIER					3
3.01 CAPITAL DRG OUTLIER PAYMENTS FOR SERVICES RENDERED PRIOR TO OCTOBER 1, 1997					3.01
4 INDIRECT MEDICAL EDUCATION ADJUSTMENT					4
4.01 TOTAL INPAT DAYS DIVIDED BY NO OF DAYS IN CR PERIOD					4.01
4.02 NUMBER OF INTERNS AND RESIDENTS FROM WORKSHEET S-3, PART I					4.02
4.03 INDIRECT MEDICAL EDUCATION PERCENTAGE					4.03
5 INDIRECT MEDICAL EDUCATION ADJUSTMENT					5
5.01 DISPROPORTIONATE SHARE ADJUSTMENT					5.01
5.02 % OF SSI RECIPIENT PAT DAYS TO MEDICARE PART A PAT DAYS					5.02
5.03 % OF MEDICAID PAT DAYS TO TOTAL DAYS ON WKST S-3, PART I					5.03
5.04 SUM OF LINES 5 AND 5.01					5.04
6 ALLOWABLE DISPROPORTIONATE SHARE PERCENTAGE					6
6 TOTAL PROSPECTIVE CAPITAL PAYMENTS					6
PART II - HOLD HARMLESS METHOD					
1 NEW CAPITAL					1
2 OLD CAPITAL					2
3 TOTAL CAPITAL					3
4 RATIO OF NEW CAPITAL TO TOTAL CAPITAL					4
5 TOTAL CAPITAL PAYMENTS UNDER 100% FEDERAL RATE					5
6 REDUCTION FACTOR FOR HOLD HARMLESS PAYMENT					6
7 REDUCED OLD CAPITAL AMOUNT					7
8 HOLD HARMLESS PAYMENT FOR NEW CAPITAL					8
9 SUBTOTAL					9
10 PAYMENT UNDER HOLD HARMLESS (GREATER OF LINE 5 OR LINE 9)					10
PART III - PAYMENT UNDER REASONABLE COST					
1 PROGRAM INPATIENT ROUTINE CAPITAL COST					1
2 PROGRAM INPATIENT ANCILLARY CAPITAL COST					2
3 TOTAL INPATIENT PROGRAM CAPITAL					3
4 CAPITAL COST PAYMENT FACTOR					4
5 TOTAL INPATIENT PROGRAM CAPITAL COST					5
PART IV - COMPUTATION OF EXCEPTION PAYMENTS					
1 PROGRAM INPATIENT CAPITAL COSTS					1
2 PROGRAM INPATIENT CAPITAL COSTS FOR EXTRAORDINARY CIRCUMSTANCES					2
3 NET PROGRAM INPATIENT CAPITAL COSTS					3
4 APPLICABLE EXCEPTION PERCENTAGE					4
5 CAPITAL COST FOR COMPARISON TO PAYMENTS					5
6 PERCENTAGE ADJUSTMENT FOR EXTRAORDINARY CIRCUMSTANCES					6
7 ADJUSTMENT TO CAPITAL MINIMUM PAYMENT LEVEL FOR EXTRAORDINARY CIRCUMSTANCES					7
8 CAPITAL MINIMUM PAYMENT LEVEL					8
9 CURRENT YEAR CAPITAL PAYMENTS					9
10 CURRENT YEAR COMPARISON OF CAPITAL MINIMUM PAYMENT LEVEL TO CAPITAL PAYMENTS					10
11 CARRYOVER OF ACCUMULATED CAPITAL MINIMUM PAYMENT LEVEL OVER CAPITAL PAYMENT					11
12 NET COMPARISON OF CAPITAL MINIMUM PYMNT LEVEL TO CAPITAL PYMNTS					12
13 CURRENT YEAR EXCEPTION PAYMENT					13
14 CARRYOVER OF ACCUMULATED CAPITAL MINIMUM PAYMENT LEVEL OVER CAPITAL PAYMENT FOR FOLLOWING PERIOD					14
15 CURRENT YEAR ALLOWABLE OPERATING AND CAPITAL PAYMENT (SEE INSTRUCTIONS)					15
16 CURRENT YEAR OPERATING AND CAPITAL COSTS (SEE INSTRUCTIONS)					16
17 CURRENT YEAR EXCEPTION OFFSET AMOUNT					17

PROVIDER NO. 14-1318 OSF HOLY FAMILY MEDICAL CENTER
 PERIOD FROM 10/01/2008 TO 09/30/2009

KPMG LLP COMPU-MAX MICRO SYSTEM
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ALLOCATION OF ALLOWABLE CAPITAL COSTS FOR EXTRAORDINARY CIRCUMSTANCES

WORKSHEET L-1
 PART I

COST CENTER DESCRIPTION		EXTRAORDI- NARY CAP- REL COSTS 0	SUBTOTAL 4A	SUBTOTAL 25	I&R COST & POST STEP- DOWN ADJS 26	TOTAL 27	
GENERAL SERVICE COST CENTERS							
1	OLD CAP REL COSTS-BLDG & FIXT						1
2	OLD CAP REL COSTS-MVBLE EQUIP						2
3	NEW CAP REL COSTS-BLDG & FIXT						3
4	NEW CAP REL COSTS-MVBLE EQUIP						4
4.01	NEW CAP REL COSTS-MVBLE EQUIP						4.01
5	EMPLOYEE BENEFITS						5
6	ADMINISTRATIVE & GENERAL						6
7	MAINTENANCE & REPAIRS						7
8	OPERATION OF PLANT						8
9	LAUNDRY & LINEN SERVICE						9
10	HOUSEKEEPING						10
11	DIETARY						11
12	CAFETERIA						12
13	MAINTENANCE OF PERSONNEL						13
14	NURSING ADMINISTRATION						14
15	CENTRAL SERVICES & SUPPLY						15
16	PHARMACY						16
17	MEDICAL RECORDS & LIBRARY						17
18	SOCIAL SERVICE						18
20	NONPHYSICIAN ANESTHETISTS						20
21	NURSING SCHOOL						21
22	I&R SERVICES-SALARY & FRINGES						22
23	I&R SERVICES-OTHER PRGM COSTS						23
24	PARAMED ED PRGM-(SPECIFY)						24
INPATIENT ROUTINE SERV COST CENTERS							
25	ADULTS & PEDIATRICS						25
34	SKILLED NURSING FACILITY						34
ANCILLARY SERVICE COST CENTERS							
37	OPERATING ROOM						37
38	RECOVERY ROOM						38
40	ANESTHESIOLOGY						40
41	RADIOLOGY-DIAGNOSTIC						41
44	LABORATORY						44
46.30	BLOOD CLOTTING FACTORS ADMIN C						46.30
49	RESPIRATORY THERAPY						49
50	PHYSICAL THERAPY						50
51	OCCUPATIONAL THERAPY						51
52	SPEECH PATHOLOGY						52
53	ELECTROCARDIOLOGY						53
55	MEDICAL SUPPLIES CHARGED TO PA						55
56	DRUGS CHARGED TO PATIENTS						56
59.97	CARDIAC REHABILITATION						59.97
59.98	HYPERBARIC OXYGEN THERAPY						59.98
59.99	LITHOTRIPSY						59.99
OUTPATIENT SERVICE COST CENTERS							
61	EMERGENCY						61
62	OBSERVATION BEDS (NON-DISTINCT						62
63.50	RHC						63.50
63.60	FQHC						63.60
OTHER REIMBURSABLE COST CENTERS							
69.10	CMHC						69.10
69.20	OUTPATIENT PHYSICAL THERAPY						69.20
69.30	OUTPATIENT OCCUPATIONAL THERAP						69.30
69.40	OUTPATIENT SPEECH PATHOLOGY						69.40
71	HOME HEALTH AGENCY						71
SPECIAL PURPOSE COST CENTERS							
85.01	PANCREAS ACQUISITION						85.01
85.02	INTESTINAL ACQUISITION						85.02
85.03	ISLET CELL ACQUISITION						85.03
95	SUBTOTALS						95
NONREIMBURSABLE COST CENTERS							
98	PHYSICIANS' PRIVATE OFFICES						98
100	CLINIC						100
100.01	RENTAL SPACE						100.01
101	CROSS FOOT ADJUSTMENTS						101
102	NEGATIVE COST CENTER						102
103	TOTAL						103
104	TOTAL STATISTICAL BASIS						104
105	UNIT COST MULTIPLIER						105
105	UNIT COST MULTIPLIER						105

PROVIDER NO. 14-1318 OSF HOLY FAMILY MEDICAL CENTER
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ANALYSIS OF PROVIDER-BASED RURAL HEALTH CLINIC/
FEDERALLY QUALIFIED HEALTH CENTER COSTS

RHC 1
COMPONENT NO: 14-3461

WORKSHEET M-1

CHECK [XX] RHC
APPLICABLE BOX: [] FQHC

	COMPEN- SATION 1	OTHER COSTS 2	TOTAL 3	RECLASSIFI- CATIONS 4	RECLASSIFIED TRIAL BALANCE 5	ADJUST- MENTS 6	NET EXPENSES FOR ALLOCATION 7	
FACILITY HEALTH CARE STAFF COSTS								
1 PHYSICIAN	1407808	153645	1561453		1561453		1561453	1
2 PHYSICIAN ASSISTANT	388242		388242		388242		388242	2
3 NURSE PRACTITIONER								3
4 VISITING NURSE								4
5 OTHER NURSE	244730		244730		244730		244730	5
6 CLINICAL PSYCHOLOGIST								6
7 CLINICAL SOCIAL WORKER								7
8 LABORATORY TECHNICIAN								8
9 OTHER FACILITY HEALTH CARE STAFF COSTS								9
10 SUBTOTAL (SUM OF LINES 1-9)	2040780	153645	2194425		2194425		2194425	10
COSTS UNDER AGREEMENT								11
11 PHYSICIAN SERVICES UNDER AGREEMENT								11
12 PHYSICIAN SUPERVISION UNDER AGREEMENT								12
13 OTHER COSTS UNDER AGREEMENT								13
14 SUBTOTAL (SUM OF LINES 11-13)								14
OTHER HEALTH CARE COSTS								
15 MEDICAL SUPPLIES		41269	41269		41269		41269	15
16 TRANSPORTATION (HEALTH CARE STAFF)		11093	11093		11093		11093	16
17 DEPRECIATION-MEDICAL EQUIPMENT								17
18 PROFESSIONAL LIABILITY INSURANCE		40841	40841		40841		40841	18
19 OTHER HEALTH CARE COSTS		133640	133640		133640		133640	19
20 ALLOWABLE GME COSTS								20
21 SUBTOTAL (SUM OF LINES 15-20)		226843	226843		226843		226843	21
22 TOTAL COSTS OF HEALTH CARE SERVICES	2040780	380488	2421268		2421268		2421268	22
COSTS OTHER THAN RHC/FQHC SERVICES								
23 PHARMACY		35759	35759		35759		35759	23
24 DENTAL								24
25 OPTOMETRY								25
26 ALL OTHER NONREIMBURSABLE COSTS		4971	4971		4971		4971	26
27 NONALLOWABLE GME COSTS								27
28 TOTAL NONREIMBURSABLE COSTS		40730	40730		40730		40730	28
FACILITY OVERHEAD								
29 FACILITY COSTS								29
30 ADMINISTRATIVE COSTS	310369	109014	419383		419383	-20031	399352	30
31 TOTAL FACILITY OVERHEAD	310369	109014	419383		419383	-20031	399352	31
32 TOTAL FACILITY COSTS	2351149	530232	2881381		2881381	-20031	2861350	32

PROVIDER NO. 14-1318 OSF HOLY FAMILY MEDICAL CENTER
 PERIOD FROM 10/01/2008 TO 09/30/2009

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ALLOCATION OF OVERHEAD TO RHC/FQHC SERVICES

RHC I
 COMPONENT NO: 14-3461

WORKSHEET M-2

CHECK ☒ RHC
 APPLICABLE BOX: ☐ FQHC

VISITS AND PRODUCTIVITY

	NUMBER OF FTE PERSONNEL 1	TOTAL VISITS 2	PRODUCTIVITY STANDARD 3	MINIMUM VISITS 4	GREATER OF COL. 3 OR COL. 4 5	
1 PHYSICIANS	4.98	23011	4200	20916		1
2 PHYSICIAN ASSISTANTS	3.15	15876	2100	6615		2
3 NURSE PRACTITIONERS			2100			3
4 SUBTOTAL	8.13	38887		27531	38887	4
5 VISITING NURSE						5
6 CLINICAL PSYCHOLOGIST						6
7 CLINICAL SOCIAL WORKER						7
8 TOTAL FTEs AND VISITS	8.13	38887			38887	8
9 PHYSICIAN SERVICES UNDER AGREEMENTS						9

DETERMINATION OF ALLOWABLE COST APPLICABLE TO RHC/FQHC SERVICES

10 TOTAL COSTS OF HEALTH CARE SERVICES	2421268	10
11 TOTAL NONREIMBURSABLE COSTS	40730	11
12 COST OF ALL SERVICES (EXCLUDING OVERHEAD)	2461998	12
13 RATIO OF RHC/FQHC SERVICES	0.983457	13
14 TOTAL FACILITY OVERHEAD	399352	14
15 PARENT PROVIDER OVERHEAD ALLOCATED TO FACILITY	2423654	15
16 TOTAL OVERHEAD	2823006	16
17 ALLOWABLE GME OVERHEAD		17
18 SUBTRACT LINE 17 FROM LINE 16	2823006	18
19 OVERHEAD APPLICABLE TO RHC/FQHC SERVICES	2776305	19
20 TOTAL ALLOWABLE COST OF RHC/FQHC SERVICES	5197573	20

PROVIDER NO. 14-1318 OSF HOLY FAMILY MEDICAL CENTER
PERIOD FROM 10/01/2008 TO 09/30/2009

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CALCULATION OF REIMBURSEMENT SETTLEMENT FOR RHC/FQHC SERVICES

RHC I
COMPONENT NO: 14-3461

WORKSHEET M-3

CHECK [XX] RHC [] TITLE V
APPLICABLE BOX: [] FQHC [XX] TITLE XVIII
[] TITLE XIX

DETERMINATION OF RATE FOR RHC/FQHC SERVICES

1	TOTAL ALLOWABLE COST OF RHC/FQHC SERVICES	5197573	1
2	COST OF VACCINES AND THEIR ADMINISTRATION	132	2
3	TOTAL ALLOWABLE COST EXCLUDING VACCINE	5197441	3
4	TOTAL VISITS	38887	4
5	PHYSICIANS VISITS UNDER AGREEMENT		5
6	TOTAL ADJUSTED VISITS	38887	6
7	ADJUSTED COST PER VISIT	133.65	7

CALCULATION OF LIMIT(1)
PRIOR TO ON OR AFTER
JANUARY 1 JANUARY 1 (SEE INSTR.)
1 2 3

8	PER VISIT PAYMENT LIMIT	75.63	76.84	8
9	RATE FOR PROGRAM COVERED VISITS	133.65	133.65	9

CALCULATION OF SETTLEMENT

10	PROGRAM COVERED VISITS EXCLUDING MENTAL HEALTH SERVICES	7279	10
11	PROGRAM COST EXCLUDING COSTS FOR MENTAL HEALTH SERVICES	972838	11
12	PROGRAM COVERED VISITS FOR MENTAL HEALTH SERVICES		12
13	PROGRAM COVERED COST FROM MENTAL HEALTH SERVICES		13
14	LIMIT ADJUSTMENT FOR MENTAL HEALTH SERVICES		14
15	GRADUATE MEDICAL EDUCATION PASS THROUGH COST		15
16	TOTAL PROGRAM COST	972838	16
16.01	PRIMARY PAYOR PAYMENTS		16.01
17	LESS: BENEFICIARY DEDUCTIBLE	86548	17
18	NET PROGRAM COST EXCLUDING VACCINES	886290	18
19	REIMBURSABLE COST OF RHC/FQHC SERVICES, EXCLUDING VACCINE	709032	19
20	PROGRAM COST OF VACCINES AND THEIR ADMINISTRATION	85	20
21	TOTAL REIMBURSABLE PROGRAM COST	709117	21
22	REIMBURSABLE BAD DEBTS		22
22.01	REIMBURSABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES		22.01
23	OTHER ADJUSTMENTS		23
24	NET REIMBURSABLE AMOUNT	709117	24
25	INTERIM PAYMENTS	622169	25
25.01	TENTATIVE SETTLEMENT (FOR FISCAL INTERMEDIARY USE ONLY)		25.01
26	BALANCE DUE COMPONENT/PROGRAM	86948	26
27	PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS)	10036	27
	IN ACCORDANCE WITH CMS PUB 15-II, CHAPTER I, SECTION 115.2		

(1) LINES 8 THROUGH 14: FISCAL YEAR PROVIDERS USE COLUMNS 1 & 2, CALENDAR YEAR PROVIDERS USE COLUMN 2 ONLY.

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COMPUTATION OF PNEUMOCOCCAL AND INFLUENZA VACCINE COST

RHC I
 COMPONENT NO: 14-3461

WORKSHEET M-4

CHECK [XX] RHC [] TITLE V
 APPLICABLE BOX: [] FQHC [XX] TITLE XVIII
 [] TITLE XIX

	PNEUMOCOCCAL 1	INFLUENZA 2	
1 HEALTH CARE STAFF COSTS	2194425	2194425	1
2 RATIO OF PNEUMOCOCCAL AND INFLUNZA VACCINE STAFF TIME TO TOTAL HEALTH CARE STAFF TIME	0.000001	0.000001	2
3 PNEUMOCOCCAL AND INFUENZA VACCINE HEALTH CARE STAFF COST	2	2	3
4 MEDICAL SUPPLIES COST - PNEUMOCOCCAL AND INFUENZA VACCINE	42	15	4
5 DIRECT COST OF PNEUMOCOCCAL AND INFLUENZA VACCINE	44	17	5
6 TOTAL DIRECT COST OF THE FACILITY	2421268	2421268	6
7 TOTAL OVERHEAD	2823006	2823006	7
8 RATIO OF PNEUMOCOCCAL AND INFUENZA VACCINE DIRECT COST TO TOTAL DICT COST	0.000018	0.000007	8
9 OVERHEAD COST - PNEUMOCOCCAL AND INFLUENZA VACCINE	51	20	9
10 TOTAL PNEUMOCOCCAL AND INFLUENZA VACCINE COST AND ITS (THEIR) ADMINISTRATION	95	37	10
11 TOTAL NUMBER OF PNEUMOCOCCAL AND INFLUENZA VACCINE INJECTIONS	113	974	11
12 COST PER PNEUMOCOCCAL AND INFLUENZA VACCINE INJECTION	0.84	0.04	12
13 NUMBER OF PNEUMOCOCCAL AND INFLUENZA VACCINE INJECTIONS ADMINISTERED TO MEDICARE BENEFICIARIES	78	467	13
14 MEDICARE COST OF PNEUMOCOCCAL AND INFLUENZA VACCINE AND ITS (THEIR) ADMINISTRATION	66	19	14
15 TOTAL COST OF PNEUMOCOCCAL AND INFLUENZA VACCINE AND ITS (THEIR) ADMINISTRATION		132	15
16 TOTAL MEDICARE COST OF PNEUMOCOCCAL AND INFLUENZA VACCINE AND ITS (THEIR) ADMINISTRATION		85	16

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WORKSHEET M-5

DESCRIPTION

PART B

2
AMOUNT

TO BE COMPLETED BY INTERMEDIARY

INTERMEDIARY NUMBER:

DATE (MO/DAY/YR) :

***** REPORT 97 ***** UTILIZATION STATISTICS *****

HOSPITAL

COST CENTERS	---- TITLE XVIII ----		----- TITLE XIX -----		----- TITLE V -----		TOTAL THIRD PARTY UTIL
	PART A 1	PART B 2	INPATIENT 3	OUTPATIENT 4	INPATIENT 5	OUTPATIENT 6	
UTILIZATION PERCENTAGES BASED ON DAYS							
25 ADULTS & PEDIATRICS	59.20		4.05				63.25 25
UTILIZATION PERCENTAGES BASED ON CHARGES							
37 OPERATING ROOM	9.06	20.82					29.88 37
41 RADIOLOGY-DIAGNOSTIC	5.01	27.48					32.49 41
44 LABORATORY	6.99	36.01					43.00 44
49 RESPIRATORY THERAPY	31.65	4.11					35.76 49
50 PHYSICAL THERAPY	1.99	25.34					27.33 50
51 OCCUPATIONAL THERAPY	7.23	16.22					23.45 51
52 SPEECH PATHOLOGY	48.13	6.82					54.95 52
53 ELECTROCARDIOLOGY		79.74					79.74 53
55 MEDICAL SUPPLIES CHARGED TO PAT	13.13	20.01					33.14 55
56 DRUGS CHARGED TO PATIENTS	28.82	18.30					47.12 56
61 EMERGENCY		30.03					30.03 61
62 OBSERVATION BEDS (NON-DISTINCT		46.99					46.99 62
101 TOTAL CHARGES	6.91	23.00					29.91 101

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***** REPORT 97 ***** UTILIZATION STATISTICS *****

SNF / NF

COST CENTERS	SNF		NF		NF		TOTAL THIRD PARTY UTIL
	----- TITLE XVIII -----		----- TITLE XIX -----		----- TITLE V -----		
	PART A 1	PART B 2	INPATIENT 3	OUTPATIENT 4	INPATIENT 5	OUTPATIENT 6	
UTILIZATION PERCENTAGES BASED ON DAYS							
34 SKILLED NURSING FACILITY	3.91						3.91 34
UTILIZATION PERCENTAGES BASED ON CHARGES							
41 RADIOLOGY-DIAGNOSTIC	0.03						0.03 41
44 LABORATORY	0.08						0.08 44
49 RESPIRATORY THERAPY	2.60						2.60 49
50 PHYSICAL THERAPY	1.25						1.25 50
51 OCCUPATIONAL THERAPY	3.97						3.97 51
52 SPEECH PATHOLOGY	3.70						3.70 52
55 MEDICAL SUPPLIES CHARGED TO PAT	0.24						0.24 55
56 DRUGS CHARGED TO PATIENTS	1.60						1.60 56
101 TOTAL CHARGES	0.31						0.31 101

COST CENTER	--- DIRECT COSTS ---		-- ALLOCATED OVERHEAD --		--- TOTAL COSTS ---		
	AMOUNT	%	AMOUNT	%	AMOUNT	%	
GENERAL SERVICE COST CENTERS							
1 OLD CAP REL COSTS-BLDG & FIXT							1
2 OLD CAP REL COSTS-MVBLE EQUIP							2
3 NEW CAP REL COSTS-BLDG & FIXT	69639	.31	-69639	-.61			3
4 NEW CAP REL COSTS-MVBLE EQUIP	1052706	4.70	-1052706	-9.24			4
4.01 NEW CAP REL COSTS-MVBLE EQUIP N	44102	.20	-44102	-.39			4.01
5 EMPLOYEE BENEFITS	2788514	12.45	-2788514	-24.48			5
6 ADMINISTRATIVE & GENERAL	4832638	21.58	-4832638	-42.42			6
7 MAINTENANCE & REPAIRS							7
8 OPERATION OF PLANT	1277108	5.70	-1277108	-11.21			8
9 LAUNDRY & LINEN SERVICE	106424	.48	-106424	-.93			9
10 HOUSEKEEPING	400654	1.79	-400654	-3.52			10
11 DIETARY	596920	2.67	-596920	-5.24			11
12 CAFETERIA							12
13 MAINTENANCE OF PERSONNEL							13
14 NURSING ADMINISTRATION							14
15 CENTRAL SERVICES & SUPPLY							15
16 PHARMACY							16
17 MEDICAL RECORDS & LIBRARY	222869	1.00	-222869	-1.96			17
18 SOCIAL SERVICE							18
20 NONPHYSICIAN ANESTHETISTS							20
21 NURSING SCHOOL							21
22 I&R SERVICES-SALARY & FRINGES A							22
23 I&R SERVICES-OTHER PRGM COSTS A							23
24 PARAMED ED PRGM-(SPECIFY)							24
INPATIENT ROUTINE SERV COST CENTERS							
25 ADULTS & PEDIATRICS	1067304	4.77	1571089	13.79	2638393	11.78	25
34 SKILLED NURSING FACILITY	899716	4.02	1800918	15.81	2700634	12.06	34
ANCILLARY SERVICE COST CENTERS							
37 OPERATING ROOM	454239	2.03	590960	5.19	1045199	4.67	37
38 RECOVERY ROOM			7328	.06	7328	.03	38
40 ANESTHESIOLOGY	10309	.05	16747	.15	27056	.12	40
41 RADIOLOGY-DIAGNOSTIC	1209591	5.40	930412	8.17	2140003	9.56	41
44 LABORATORY	1036642	4.63	707108	6.21	1743750	7.79	44
46.30 BLOOD CLOTTING FACTORS ADMIN CO							46.30
49 RESPIRATORY THERAPY	49266	.22	38352	.34	87618	.39	49
50 PHYSICAL THERAPY	343414	1.53	438746	3.85	782160	3.49	50
51 OCCUPATIONAL THERAPY	75187	.34	59281	.52	134468	.60	51
52 SPEECH PATHOLOGY	6990	.03	4496	.04	11486	.05	52
53 ELECTROCARDIOLOGY	158015	.71	205614	1.80	363629	1.62	53
55 MEDICAL SUPPLIES CHARGED TO PAT	423331	1.89	359817	3.16	783148	3.50	55
56 DRUGS CHARGED TO PATIENTS	759538	3.39	442475	3.88	1202013	5.37	56
59.97 CARDIAC REHABILITATION							59.97
59.98 HYPERBARIC OXYGEN THERAPY							59.98
59.99 LITHOTRIPSY							59.99
61 EMERGENCY	715311	3.19	818162	7.18	1533473	6.85	61
62 OBSERVATION BEDS (NON-DISTINCT)							62

PROVIDER NO. 14-1318 OSF HOLY FAMILY MEDICAL CENTER
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COST CENTER		--- DIRECT COSTS ---		-- ALLOCATED OVERHEAD --		--- TOTAL COSTS ---		
		AMOUNT	%	AMOUNT	%	AMOUNT	%	
63.50	RHC	2861350	12.78	2423654	21.28	5285004	23.60	63.50
63.60	FQHC							63.60
	OTHER REIMBURSABLE COST CENTERS							
	OUTPATIENT SERVICE COST CENTERS							
69.10	CMHC							69.10
69.20	OUTPATIENT PHYSICAL THERAPY							69.20
69.30	OUTPATIENT OCCUPATIONAL THERAPY							69.30
69.40	OUTPATIENT SPEECH PATHOLOGY							69.40
71	HOME HEALTH AGENCY							71
	SPECIAL PURPOSE COST CENTERS							
85.01	PANCREAS ACQUISITION							85.01
85.02	INTESTINAL ACQUISITION							85.02
85.03	ISLET CELL ACQUISITION							85.03
	NONREIMBURSABLE COST CENTERS							
98	PHYSICIANS' PRIVATE OFFICES	929054	4.15	976415	8.57	1905469	8.51	98
100	CLINIC							100
100.01	RENTAL SPACE							100.01
101	CROSS FOOT ADJUSTMENTS							101
102	NEGATIVE COST CENTER							102
103	TOTAL	22390831	100.00	0	.00	22390831	100.00	103

PROVIDER NO. 14-1318 OSF HOLY FAMILY MEDICAL CENTER
PERIOD FROM 10/01/2008 TO 09/30/2009

KPMG LLP COMPU-MAX MICRO SYSTEM

VERSION: 2010.02
03/12/2010

**** THIS PROVIDER IS NOT A PPS HOSPITAL

III. COST TO CHARGE RATIO FOR OUTPATIENT SERVICES

1. TOTAL PROGRAM (TITLE XVIII) OUTPATIENT COST EXCLUDING SERVICES NOT SUBJECT TO OPPS. (WKST D, PART V, COLUMNS 2, 2.01, 3, 3.01, 4, 4.01, 5, 5.01, 5.03 & 5.04 x COLUMN 1.01 LESS LINES 45, 50 - 52, 57, 64, 65 & SUBSCRIPTS, & 66)	2711848
2. TOTAL PROGRAM (TITLE XVIII) OUTPATIENT CHARGES EXCLUDING SERVICES NOT SUBJECT TO OPPS. (WKST D, PART V, LINE 104, COLUMNS 2, 2.01, 3, 3.01, 4, 4.01, 5, 5.01, 5.03 & 5.04 LESS LINES 45, 50 - 52, 57, 64, 65 & SUBSCRIPTS, & 66)	9479739
3. RATIO OF COST TO CHARGES (LINE 1 / LINE 2)	.286

 COMPU-MAX CMS-2552-96 EDIT REPORT

I. OPTIONS SELECTED:
 OPTION 20, 6
 OPTION 21, 4, 8,10
 OPTION 60, 5

COMPU-MAX - CMS-2552-96 - SETTLEMENT SUMMARY, VERSION 2010.02

	TITLE V	TITLE XVIII PART A	TITLE XVIII PART B	TITLE XIX	
	1	2	3	4	
1 HOSPITAL		172839	-126778		1
2 SUBPROVIDER I					2
3 SWING BED - SNF		165514			3
4 SWING BED - NF					4
5 SKILLED NURSING FACILITY					5
6 NURSING FACILITY					6
7 HOME HEALTH AGENCY					7
8 O/P REHAB PROVIDER					8
9 RURAL HEALTH CLINIC I			86948		9
100 TOTAL		338353	-39830		100

 Explanation of error code types:

1000 - The '1000' level error codes (in the range from 1000-1999) are CMS-required Electronic Cost Report (ECR) edit messages. These will prohibit ECR file generation by Compu-Max for submission to your Medicare Fiscal Intermediary, and will be used by the FI as a basis of rejection should your file be received by the FI with such errors.

2000 - Errors in the range of 2000-2999 are CMS-required edits that identify potential inconsistencies and/or missing data items. These items should be resolved at the provider site and appropriate worksheets and/or data submitted with the cost report. Failure to submit the appropriate data with your cost report may result in payments being withheld pending resolution of the issue(s).

**** - KPMG error messages check for additional possible errors not included with the CMS-required edits, and cannot be used as a basis for rejection of the ECR data file or the cost report.

(*) - Error messages marked with an asterisk (*) at the end of the message indicate a logical problem with the cost report, and data must be corrected before a valid cost report can be generated.

(I) - Messages preceded by (I) are informational and are not errors.

II. 1000 LEVEL ERRORS

III. 2000 LEVEL ERRORS

2055S - IF WKST S-2, LINE 32 = 'N' AND EITHER WKST C, PART I, SUM OF COLS 6 & 7 OR WKST B, PART I, COL 27 EQUAL ZERO, THEN BOTH SHOULD BE ZERO FOR LINE 38

2055S - IF WKST S-2, LINE 32 = 'N' AND EITHER WKST C, PART I, SUM OF COLS 6 & 7 OR WKST B, PART I, COL 27 EQUAL ZERO, THEN BOTH SHOULD BE ZERO FOR LINE 40

2027 - WKST C, PART I, LINE 63.50, COL 11 SHOULD NOT BE MORE THAN 100% OR LESS THAN .1%

IV. KPMG LEVEL ERRORS

(KPMG edits cannot be used as a basis of cost report or ECR file rejection.)

**** - WORKSHEET A, COLUMN 7, LINE 12 EQUALS 0 BUT THERE ARE STATISTICS IN COLUMN 12 OF WORKSHEET B-1

**** - WORKSHEET A, COLUMN 7, LINE 15 EQUALS 0 BUT THERE ARE STATISTICS IN COLUMN 15 OF WORKSHEET B-1

**** - WORKSHEET A, COLUMN 7, LINE 16 EQUALS 0 BUT THERE ARE STATISTICS IN COLUMN 16 OF WORKSHEET B-1

**** - WORKSHEET B-1, LINE 12 HAS STATISTICS, BUT THERE IS NO COST ON WORKSHEET A, COLUMN 7

**** - WORKSHEET B-1, LINE 15 HAS STATISTICS, BUT

THERE IS NO COST ON WORKSHEET A, COLUMN 7

**** - WORKSHEET B-1, LINE 16 HAS STATISTICS, BUT
THERE IS NO COST ON WORKSHEET A, COLUMN 7

**** - WORKSHEET B-1, LINE 38 HAS STATISTICS, BUT
THERE IS NO COST ON WORKSHEET A, COLUMN 7

**** - WORKSHEET B-1, LINE 38 HAS STATISTICS, BUT
THERE ARE NO CHARGES ON WORKSHEET C, COLUMNS 6 AND/OR 7

**** - WORKSHEET B-1, LINE 40 HAS STATISTICS, BUT
THERE ARE NO CHARGES ON WORKSHEET C, COLUMNS 6 AND/OR 7

**** - WORKSHEET A, COLUMN 7, LINE 40 DOES NOT EQUAL 0, BUT
THERE ARE NO CHARGES ON WORKSHEET C, COLUMNS 6 AND/OR 7

**** - WORKSHEET G-1 END-OF-PERIOD FUND BALANCES DO NOT EQUAL WORKSHEET G
FUND BALANCES FOR COLUMN 1
FUND BALANCE PER WKST G = 14962042
FUND BALANCE PER WKST G-1 = 14962041
DIFFERENCE = 1

V. INFORMATIONAL MESSAGES

- (I) - THE TOTAL CALCULATED FOR WORKSHEET A-8-1, PART B, COLUMN 6, HAS BEEN
TRANSFERRED TO WORKSHEET A-8, LINE 14. THE TOTAL FOR WORKSHEET A-8
THAT YOU INPUT HAS BEEN INCREASED BY \$1,359,423
- (I) - THE TOTAL CALCULATED FOR WORKSHEET A-8-2, COLUMN 18, HAS BEEN
TRANSFERRED TO WORKSHEET A-8, LINE 12. THE TOTAL FOR WORKSHEET A-8
THAT YOU INPUT HAS BEEN DECREASED BY \$256,788
- (I) - THE TOTAL CALCULATED FOR WKST A-8-4 (PHYSICAL THERAPY),
LINE 69 HAS BEEN TRANSFERRED TO WORKSHEET A-8, LINE 26.
TOTAL FOR WORKSHEET A-8 THAT YOU INPUT HAS BEEN DECREASED BY \$3,917
- (I) - A PROTESTED AMOUNT HAS BEEN ENTERED ON WORKSHEET E, PART B, LINE 36
FOR FACILITY (HOSPITAL)
- (I) - A PROTESTED AMOUNT HAS BEEN ENTERED ON WORKSHEET E-2, LINE 22, COL 1
FOR FACILITY (SWING BED-S.N.F.), TITLE 18
- (I) - A PROTESTED AMOUNT HAS BEEN ENTERED ON WORKSHEET E-3, PART II, LINE 34
FOR FACILITY (HOSPITAL)

ECR TO COMPU-MAX FILE CONVERSION UTILITY
TRANSMITTAL #21 - CMS-2552-96

ELECTRONIC FILE NAME: C:\255296\CMTEMP\EC141318.09B

COMPU-MAX FILE NAME: C:\255296\CMTEMP\CRECTEMP

PROVIDER NUMBER: 14-1318

SOFTWARE VENDOR: R01
KPMG LLP - COMPU-MAX MICRO - DATE APPROVED: 02/19/10

CREATION DATE: 3/12/2010

CREATION TIME: 16:15

PROVIDER NAME: OSF HOLY FAMILY MEDICAL CENTER

FISCAL YEAR BEGINNING: 10/01/2008

FISCAL YEAR ENDING: 09/30/2009

ECR FINGERPRINT:

REMARKS:

 ELECTRONIC REPORTING FILE VALIDATION AND EDIT REPORT

CMS REQUIRED EDITS ARE APPLIED AT TWO LEVELS:

- LEVEL I EDITS ARE THOSE WHICH TEST THE FORMAT OF THE DATA TO IDENTIFY
 FOR CORRECTION THOSE ERROR CONDITIONS WHICH MAY RESULT IN A
 COST REPORT REJECTION. INTERMEDIARIES MAY REJECT ALL ELECTRONIC
 COST REPORTING FILES WHICH CONTAIN ONE OR MORE LEVEL I EDIT ERRORS.
 LEVEL I EDITS ARE IDENTIFIED WITH NUMBERS BETWEEN 1000 AND 1999.
- LEVEL II EDITS IDENTIFY POTENTIAL INCONSISTENCIES AND/OR MISSING DATA ITEMS.
 THESE ITEMS SHOULD BE RESOLVED AT THE PROVIDER SITE AND APPROPRIATE
 WORKSHEETS AND/OR DATA SUBMITTED WITH THE COST REPORT. FAILURE TO
 SUBMIT THE APPROPRIATE DATA WITH YOUR COST REPORT MAY RESULT IN
 PAYMENTS BEING WITHHELD PENDING RESOLUTION OF THE ISSUE(S).
 LEVEL II EDITS ARE IDENTIFIED WITH NUMBERS BETWEEN 2000 AND 2999.

WORKSHEET A COST CENTER LIST: (THE ASTERISK INDICATES THAT THERE IS
 NO DIRECT INPUT DATA ASSOCIATED WITH
 THE COST CENTER)

CMS EDIT NO.			
1	OLD CAP REL COSTS-BLDG & FIXT	0100	**
2	OLD CAP REL COSTS-MVBLE EQUIP	0200	**
3	NEW CAP REL COSTS-BLDG & FIXT	0300	
4	NEW CAP REL COSTS-MVBLE EQUIP	0400	
4 1	NEW CAP REL COSTS-MVBLE EQUIP NH	0401	
5	EMPLOYEE BENEFITS	0500	
6	ADMINISTRATIVE & GENERAL	0600	
7	MAINTENANCE & REPAIRS	0700	**
8	OPERATION OF PLANT	0800	
9	LAUNDRY & LINEN SERVICE	0900	
10	HOUSEKEEPING	1000	
11	DIETARY	1100	
12	CAFETERIA	1200	
13	MAINTENANCE OF PERSONNEL	1300	**
14	NURSING ADMINISTRATION	1400	**
15	CENTRAL SERVICES & SUPPLY	1500	
16	PHARMACY	1600	
17	MEDICAL RECORDS & LIBRARY	1700	
18	SOCIAL SERVICE	1800	**
20	NONPHYSICIAN ANESTHETISTS	2000	**
21	NURSING SCHOOL	2100	**
22	I&R SERVICES-SALARY & FRINGES APPRVD	2200	**
23	I&R SERVICES-OTHER PRGM COSTS APPRVD	2300	**
24	PARAMED ED PRGM-(SPECIFY)	2400	**
25	ADULTS & PEDIATRICS	2500	
34	SKILLED NURSING FACILITY	3400	
37	OPERATING ROOM	3700	
38	RECOVERY ROOM	3800	
40	ANESTHESIOLOGY	4000	
41	RADIOLOGY-DIAGNOSTIC	4100	
44	LABORATORY	4400	
4630	BLOOD CLOTTING FACTORS ADMIN COSTS	4650	**
49	RESPIRATORY THERAPY	4900	
50	PHYSICAL THERAPY	5000	

 ELECTRONIC REPORTING FILE VALIDATION AND EDIT REPORT (CONTINUED)

CMS
 EDIT NO.

51	OCCUPATIONAL THERAPY	5100	
52	SPEECH PATHOLOGY	5200	
53	ELECTROCARDIOLOGY	5300	
55	MEDICAL SUPPLIES CHARGED TO PATIENTS	5500	
56	DRUGS CHARGED TO PATIENTS	5600	
5997	CARDIAC REHABILITATION	3997	**
5998	HYPERBARIC OXYGEN THERAPY	3998	**
5999	LITHOTRIPSY	3999	**
61	EMERGENCY	6100	
62	OBSERVATION BEDS (NON-DISTINCT PART)	6200	
6350	RHC	6310	
6360	FQHC	6320	**
6910	CMHC	6910	**
6920	OUTPATIENT PHYSICAL THERAPY	6920	**
6930	OUTPATIENT OCCUPATIONAL THERAPY	6930	**
6940	OUTPATIENT SPEECH PATHOLOGY	6940	**
71	HOME HEALTH AGENCY	7100	**
85 1	PANCREAS ACQUISITION	8510	**
85 2	INTESTINAL ACQUISITION	8520	**
85 3	ISLET CELL ACQUISITION	8530	**
88	INTEREST EXPENSE	8800	
98	PHYSICIANS' PRIVATE OFFICES	9800	
100	CLINIC	7950	**
100 1	RENTAL SPACE	7951	**

ELECTRONIC REPORTING FILE VALIDATION AND EDIT REPORT (CONTINUED)

CMS
EDIT NO.

2055S IF EITHER TOTAL CHARGES ON WKST C, PART I, COL 8, LINE 38
OR TOTAL COSTS ON WKST B, COL 27 FOR THE SAME COST CENTER
ARE EQUAL TO ZERO THEN BOTH SHOULD BE ZERO

2055S IF EITHER TOTAL CHARGES ON WKST C, PART I, COL 8, LINE 40
OR TOTAL COSTS ON WKST B, COL 27 FOR THE SAME COST CENTER
ARE EQUAL TO ZERO THEN BOTH SHOULD BE ZERO

WORKSHEET E-1 - INTERIM PAYMENT SUMMARY

		PART A	PART B	TOTAL
1	HOSPITAL	1420755	1914376	3335131
2	SUBPROVIDER I			
3	SWING-BED SNF	1046602		1046602
4	SKILLED NURSING FAC	64726		64726
5	HOME HEALTH AGENCY I			
6	CORE			
	TOTAL	2532083	1914376	4446459

WORKSHEET S - SETTLEMENT SUMMARY

	TITLE V	TITLE XVIII PART A	TITLE XVIII PART B	TITLE XIX	
	1	2	3	4	
1	HOSPITAL		172839	-126778	1
2	SUBPROVIDER I				2
3	SWING BED - SNF		165514		3
4	SWING BED - NF				4
5	SKILLED NURSING FACILITY				5
6	NURSING FACILITY				6
7	HOME HEALTH AGENCY				7
8	CORF				8
9	RHC			86948	9
100	TOTAL	338353	-39830		100